Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYNLLUNIO POBL A SICRWYDD PERFFORMIAD
PEOPLE PLANNING AND PERFORMANCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 June 2021
TEITL YR ADRODDIAD: TITLE OF REPORT:	Corporate Risk Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Steve Moore, Chief Executive Andrew Carruthers, Director of Operations Lisa Gostling, Director of Workforce and OD Huw Thomas, Director of Finance Ros Jervis, Director of Public Health Lee Davies, Director of Strategic Development & Operational Planning
SWYDDOG ADRODD: REPORTING OFFICER:	Jo Wilson, Board Secretary Charlotte Beare, Head of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

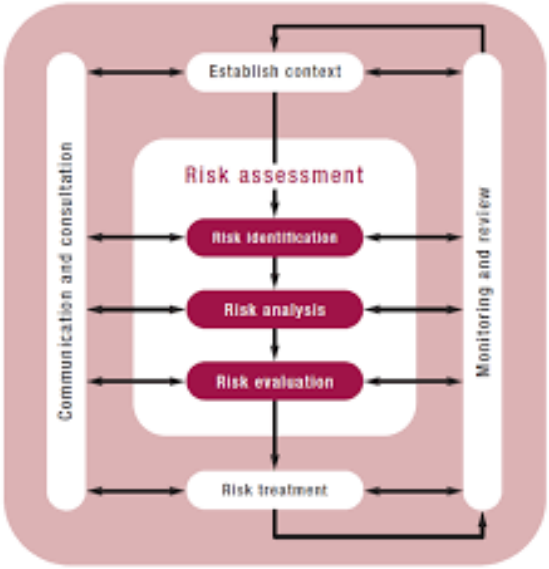
ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The People, Planning and Performance Assurance Committee (PPPAC) is asked to request assurance from Executive Directors that the corporate risks in the attached report are being managed effectively.

Cefndir / Background

Effective risk management requires a 'monitoring and review' structure to be in place to ensure that risks are effectively identified and assessed and that appropriate controls and responses are in place.



(Risk Management Process, ISO 31000)

The Board's Committees are responsible for the monitoring and scrutiny of corporate level risks within their remit. They are responsible for:

- Seeking assurance on the management of principal risks on the Board Assurance Framework (BAF)/Corporate Risk Report (CRR) and provide assurance to the Board that risks are being managed effectively & report areas of significant concern, for example, where risk appetite is exceeded, lack of action, etc.
- Reviewing principal and operational risks over tolerance and where appropriate recommend the 'acceptance' of risks that cannot be brought within the Hywel Dda University Health Board's (HDdUHB's) risk appetite/tolerance.
- Providing annual reports to the Audit, Risk and Assurance Committee (ARAC) on the effectiveness of the risk management process and management of risks within its remit.
- Identifying through discussions any new/emerging risks and ensure these are assessed by management.
- Signposting any risks out of its remit to the appropriate HDdUHB Committee/Sub-Committee/Group.
- Using risk registers to inform meeting agendas.

The Executive Team agree the content of the CRR. These risks have been identified via a top down and bottom up approach and are either:

- Associated with the delivery of the objectives set out in the HDdUHB's Annual Plan; or
- Operational risks escalated by individual Directors and agreed by the Executive Team as they are of significant concern and require corporate oversight and management.

Each risk on the CRR has been mapped to a Board Level Committee to ensure that risks on the CRR are being managed appropriately, taking into account the gaps, planned actions and agreed tolerances, and to provide assurance to the Board through their Committee update report on the management of these risks.

The Board has delegated a proportion of its role of scrutiny of assurances to its Committees to make the most appropriate and efficient use of expertise. Therefore, Committees should also ensure that assurance reports relevant to the principal risks are received and scrutinised, and an assessment made as to the level of assurance it provides, taking into account the validity and reliability i.e. source, timeliness, methodology behind its generation and its compatibility with other assurances. This will enable the Board to place greater reliance on assurances if they are confident that they have been robustly scrutinised by one of its Committees; and provide them with greater confidence about the likely achievement of strategic objectives, as well as providing a sound basis for decision-making. It is the role of Committees to challenge where assurances in respect of any component are missing or inadequate. Any gaps should be escalated to the Board.

Risk reporting in HDdUHB is outlined in Appendix 1.

Asesiad / Assessment

The PPPAC's Terms of Reference state that it will:

2.9 Seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action.

2.10 Recommend acceptance of risks that cannot be brought within the UHBs risk appetite/tolerance to the Board through the Committee Update Report.

Board Committees receive corporate risks at meetings prior to the Board to fully review and receive assurance that corporate risks are being managed effectively. Where the Committee is not provided with this assurance, the Committee is then able to request additional assurance from the risk owners (Executive Directors), by way of a specific report at the following meeting.

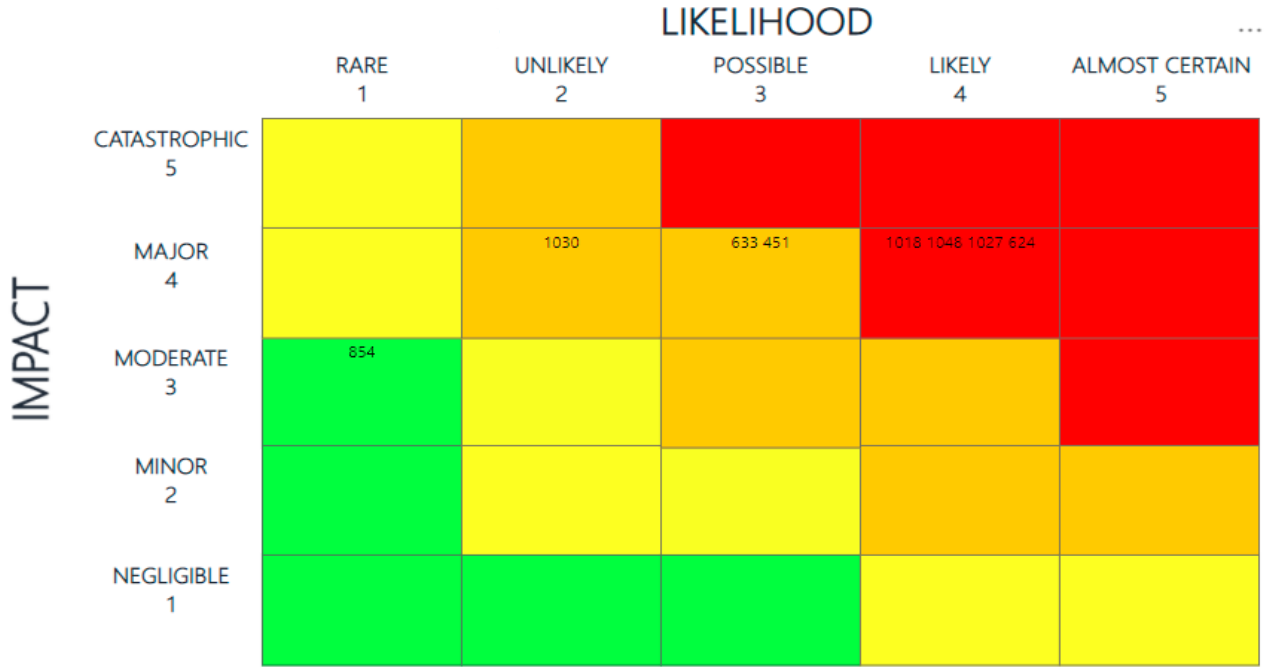
The Committee is asked to seek assurance from risk owners that each risk is being managed effectively and will be brought within the HDdUHB tolerance and/or objective will be achieved. The Committee is asked not to devolve its responsibility for seeking assurances on corporate risks to its Sub-Committee structure, however it can reassign risks to another Board level Committee if it is agreed these better fit within their remit.

There are 8 corporate risks that have been aligned to PPPAC. A summary of these risks is outlined in Appendix 2, with individual risks outlined in Appendix 3. Each of these risks have been entered onto a 'risk on a page' template which includes information relating to the strategic objective, controls, assurances, performance indicators and action plans to address any gaps in controls and assurances. The risk scoring matrix is outlined in Appendix 4.

Below is a summary of changes since the previous report in December 2020:

Total number of risks	8	
New risks	2	*See Note 1*
De-escalated/Closed risks	2	*See Note 2*
Increase in risk score ↑	0	
Reduction in risk score ↓	2	*See Note 3*
No change in risk score →	4	*See Note 4*

The heatmap below includes the risks currently aligned to PPPAC and has been obtained from the Risk Performance dashboard. The information reflects the risk information extracted from Datix as of 10th June 2021 based on the 8 Corporate Risks assigned to the PPPAC.



Note 1 – New Risks
Since the previous report, two new risks have been added to the CRR and aligned to PPPAC.

Risk Reference and Title	Executive Lead	New/ Escalated	Date	Reason
1048 - Risk to the delivery of planned care services set out in the Annual Recovery Plan 2021/22	Director of Operations	New	03/03/21	This risk was added to the CRR in March 2021 following the second wave of the pandemic. While case incidence of COVID-19 has regressed and its direct impact on acute care reduced, the level of risk escalation remains. Limits to staffing resource both in theatre, and post operatively, was a challenge before COVID-19. The additional factors of providing separate staffing teams for red and green areas, is an added challenge and has shaped the model of provision suggested on each site. It is evident that our realisable capacity in the short term will not match that available prior to March 2020. The plans that have been developed do however reflect the maximum capacity HDdUHB can achieve within the footprint of our existing hospital sites, particularly during the first half of 2021. Whilst the plan for increased delivery of elective work (outlined within the HDdUHB Annual Plan) is progressing in accordance with the plan outlined, challenges and risks around availability of supporting bed and theatre capacity remain which limits the ability of our clinical teams to expand activity delivery to pre-COVID-19 levels.
1030 - Reputational risk if the Health Board is perceived to not deliver the mass vaccination programme	Director of Public Health	New	11/12/20	This risk was added to the CRR in December 2020 to reflect the challenges in delivering the mass vaccination programme. The Board have approved the Mass Vaccination Delivery Plan, which addressed many

				of the previously articulated gaps in control. The plan is progressing at pace and is being managed by the Bronze Vaccination Delivery Group and overseen by the Silver Tactical Group. As we move through the programme, achieving each milestone, we continue to manage programme delivery despite regular advice and policy changes within the context of unpredictable and inconsistent vaccine supplies.

Note 2 – Closed/De-escalated Risks
Since the previous report, eight corporate risks aligned to this Committee have been closed or de-escalated.

Risk Ref & Title	Exec Lead	Closed/ De-escalated	Date	Reason
1028 - Delivery of Quarter (Q)3/4 Operating Plan - Risk that Primary Care contractors may not be able to operate	Director of Primary Care, Community and Long Term Care	Closed	03/03/21	The Executive Team agreed to close this risk as the level of infection in the community had reduced and the risk was within tolerance.
371 - Inability to meet WG (Welsh Government) target for clinical coding and decision-making will be based on inaccurate/ incomplete information	Director of Finance	De-escalated to Directorate Level	03/03/21	The Executive Team agreed to de-escalate this risk as funding for new clinical coders has been agreed, with trainees are now in post. Although it will take up to 18 months for individuals to be fully trained, it was agreed this risk will be managed at directorate level going forward. A recovery plan has been requested by the Information Governance Sub Committee to address the backlog.

Note 3 – Increase/Decrease in Current Risk Score
Since the previous report, the following changes have been made to the current risk score of the following corporate risk.

Risk Reference & Title	Previous Risk Report Dec-20	Risk Score Jun-21 (Lxl)	Date of Review	Update

	(LxI)			
624 - Ability to maintain and address backlog maintenance and develop infrastructure to support long term strategic objectives (Director of Finance)	5x4=20	**4x4=16** ↓	14/04/21	This risk has been reduced since the previous meeting based on knowledge of Welsh Government (WG) Capital Fund for imaging priorities, the Welsh Targeted Improvement Programme for Estates Infrastructure, capital receipts during 2021 and the Fire and Major Infrastructure business cases.
854 - Risk that HDdUHB's Response to COVID-19 will be larger than required for actual demand (Chief Executive Officer)	2x3=6	**1x3=3** ↓	20/05/21	Likelihood has been further reduced in light of the growing certainty of achieving our year-end financial target. The likelihood also recognises that limits to our ability to grow our bed base reduce the risk of over-capacity and our modelling is informing the scale of gap. The WG funding process for COVID-19 has been clarified and our current forecast out turn is in line with pre-COVID-19 plans at £25m. Likelihood further reduced in light of the growing certainty of achieving our year-end financial target.

Note 4 - No change in risk score
There have been no changes in the following risk scores since they were reported to the previous meeting.

Risk Reference, Title & Risk Owner	**Previous Risk Report Dec-20 (LxI)**	**Risk Score Jun-21 (LxI)**	**Date of Review**	**Update**
1027 - Delivery of the Quarter 3/4 Operating Plan - Delivery of integrated community and acute unscheduled care services (Director of Operations)	4×4=16	**4×4=16**	26/05/21	While case incidence of COVID-19 has regressed and its direct impact on acute care reduced, the level of risk escalation remains. The indirect impact of COVID-19 has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. As a consequence, we continue therefore to have reduced availability of beds

				across acute sectors. This has reduced staffed bed availability across both sectors and has led to increasing delays in the discharge pathway and increasing delays for patients accessing unscheduled care services due to reduced capacity at Emergency Departments (ED). The situation remains fluid and changeable. This risk will be refreshed in Q2.
451 - Cyber Security Breach (Director of Finance)	3×4=12	**3×4=12**	07/06/21	There are daily threats to systems which are managed by NHS Wales Informatics Service (NWIS) and HDdUHB. Current patching levels within HDdUHB is on average 94% for desktop/laptops and 91% for the server infrastructure (May 2021). The patching levels fluctuate during the month depending on the number of updates released by the third party vendor. Alongside the fluctuations, there is lack of capacity to undertake this continuous work at the pace required. Impact score is 4 as a cyber-attack has the potential to severely disrupt service provision across all sites for a significant amount of time, however the processes and controls in place have reduced the likelihood due to the improvements in patching.
633 - Ability to meet the 1% improvement target per month for waiting times for 2020/21 for the new Single Cancer Pathway (Director of Operations)	3x4=12	**3x4=12**	09/06/21	The impact of COVID-19 may increase the risk of being unable to meet the target due to recommendations from Royal Colleges to suspend diagnostics and some surgery that are aerosol generating. During the pandemic, endoscopy was centralised in Glangwili General Hospital (GGH). Endoscopy services were reinstated on all 4 hospital sites, with capacity increasing to 53%. With the

				introduction of a Green pathway in Endoscopy as of 7th June 2021, capacity will increase to 81%. High acuity elective cancer surgery with green pathway and green Intensive Therapy Unit(ITU)/Higher Dependency Unit(HDU) commenced in Prince Phillip Hospital (PPH) & Bronglais General Hospital (BGH) on 6 July 2020 with Withybush General Hospital (WGH) commencing intermediate surgery on the 10 August 2020. Following the second wave of COVID-19 in December 2020, all green HDU/ITU pathways have been reinstated and the surgical backlog has been addressed. A full COVID-19 plan is in place.
1018 - Delivery of Q3/4 Operating Plan – Insufficient workforce to support delivery of essential services (Director of Workforce and OD)	3×4=12	**3×4=12**	10/02/21	This risk is currently under review to reflect the workforce risk to delivery of the new Annual Recovery Plan 2021/22. This will not be ready until the detail in the plan has been finalised.

Argymhelliad / Recommendation

PPPAC is asked to seek assurance that:

- All identified controls are in place and working effectively.
- All planned actions will be implemented within stated timescales and will reduce the risk further and/or mitigate the impact, if the risk materialises.

and to challenge where assurances are inadequate.

This in turn will enable PPPAC to provide the necessary assurance (or otherwise) to the Board that HDdUHB is managing these risks effectively.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	Included in the report
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Included in the report

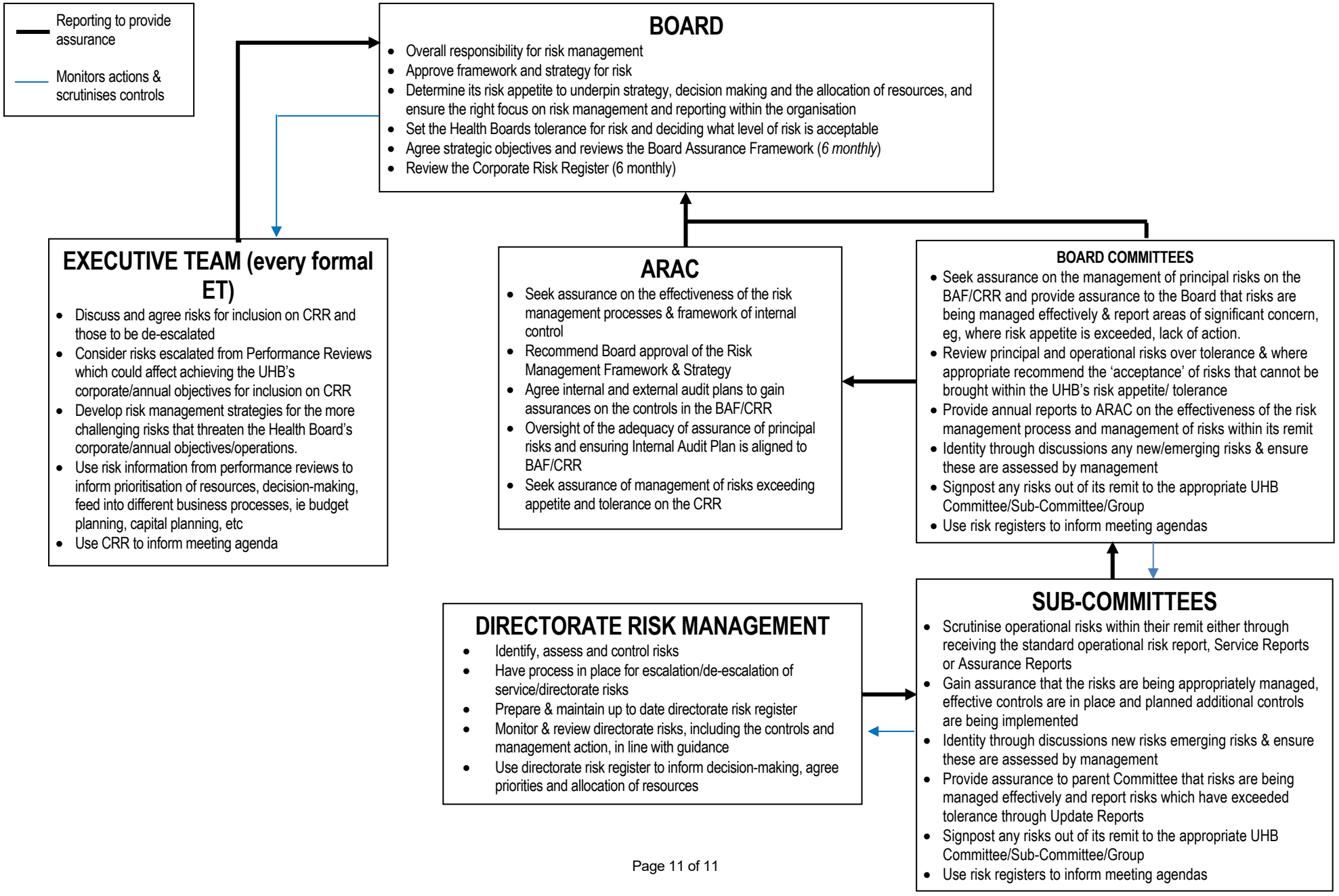
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Underpinning risk on the Datix Risk Module from across HDdUHB's services reviewed by risk leads/owners
Rhestr Termau: Glossary of Terms:	Current Risk Score - Existing level of risk taking into account controls in place Target Risk Score - The ultimate level of risk that is desired by the organisation when planned controls (or actions) have been implemented Tolerable risk – this is the level of risk that the Board agreed for each domain in September 2018 - Risk Appetite Statement attached to Operational Risks Report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cynllunio Pobl a Sicrwydd Perfformiad: Parties / Committees consulted prior to People Planning and Performance Assurance Committee:	Relevant Executive Directors

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts from report however impacts of each risk are outlined in risk description.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from report however impacts of each risk are outlined in risk description.
Gweithlu: Workforce:	No direct impacts from report however impacts of each risk are outlined in risk description.

Risg: **Risk:**	No direct impacts from report however organisations are expected to have effective risk management systems in place.
Cyfreithiol: **Legal:**	No direct impacts from report however proactive risk management including learning from incidents and events contributes towards reducing/eliminating recurrence of risk materialising and mitigates against any possible legal claim with a financial impact.
Enw Da: **Reputational:**	Poor management of risks can lead to loss of stakeholder confidence. Organisations are expected to have effective risk management systems in place and take steps to reduce/mitigate risks.
Gyfrinachedd: **Privacy:**	No direct impacts.
Cydraddoldeb: **Equality:**	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.

Appendix 1 – Committee Reporting Structure



Risk Ref	Risk (for more detail see individual risk entries)	Strategic Obejctive	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Jun-21	Trend	Target Risk Score	Risk on page no...
624	Ability to maintain and address backlog maintenance and develop infrastructure to support long term strategic objectives	6	Davies, Lee	Business objectives/projects	6	5x4=20	4x4=16	↓	4x4=16 Accepted	3
1018	Insufficient workforce to support delivery of essential services	5	Gostling, Lisa	Workforce/OD	8	4x4=16	4x4=16	→	3x4=12	7
1027	Delivery of the Plan in Quarter 1- Delivery of integrated community and acute unscheduled care services	5	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4x4=16	4x4=16	→	3x4=12	11
1048	Risk to the delivery of planned care services set out in the Annual Recovery Plan 2021/22	5	Carruthers, Andrew	Safety - Patient, Staff or Public	6	N/A	4x4=16	NEW	3x4=12	15
451	Cyber Security Breach	5	Thomas, Huw	Service/Business interruption/disruption	6	3x4=12	3x4=12	→	3x4=12 Accepted	18
633	Ability to meet the 75% target for waiting times for 2020/21 for the new Single Cancer Pathway (SCP)	5	Carruthers, Andrew	Quality/Complaints/Audit	8	3x4=12	3x4=12	→	3x2=6	22
1030	Reputational risk if the Health Board is perceived to not deliver the mass vaccination programme	5	Jervis, Ros	Adverse publicity/reputation	8	N/A	2x4=8	NEW	2x4=8	25
854	Risk that Hywel Dda's Response to COVID-19 will be larger than required for actual demand	5	Moore, Steve	Adverse publicity/reputation	8	2x3=6	1x3=3	↓	1x3=3	28

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Management	Tends to be detailed assurance but lack independence
2nd Line	Corporate Oversight	Less detailed but slightly more independent
3rd Line	Independent Assurance	Often less detail but truly independent

Key - Assurance Required	
	Detailed review of relevant information
	Medium level review
	Cursory or narrow scope of review

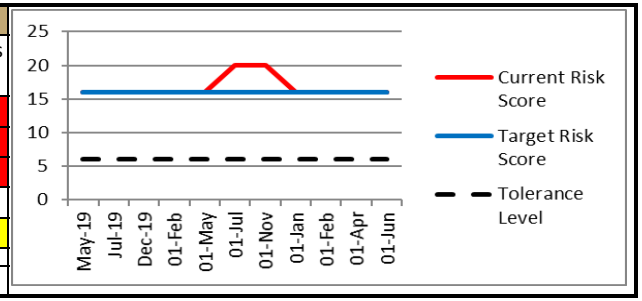
NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you

Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective and in proportion to the risk
INSUFFICIENT	Insufficient information at present to judge the adequacy/effectiveness of the controls

Date Risk Identified:	Sep-18	**Executive Director Owner:**	Davies, Lee	**Date of Review:**	Jun-21
Strategic Objective:	6. Sustainable use of resources	**Lead Committee:**	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Jul-21

Risk ID:	**624**	**Principal Risk Description:**	There is a risk the UHB will not be able to maintain and address either the backlog maintenance or development of its estate, medical equipment and digital infrastructure, that it is safe and fit for purpose. This is caused by insufficient capital, both from the All Wales Capital Programme and Discretionary Capital allocation. This could lead to an impact/affect on delivery of strategic objectives, service improvement/development and delivery of day to day patient care.
Does this risk link to any Directorate (operational) risks?		Yes	

Risk Rating:(Likelihood x Impact)	
Domain:	Business objectives/projects
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	4×4=16
30/05/2019 - Board 'Accept' Target Risk	
Tolerable Risk:	6
Trend:	↓



Rationale for CURRENT Risk Score:
Based on knowledge of Welsh Government Capital Fund for imaging priorities, the Welsh Targeted Improvement Programme for Estates Infrastructure, capital receipts during 2021 and the Fire and Major Infrastructure business cases, this risk narrative has been reviewed and the risk score reduced from 20 to 16.

Rationale for TARGET Risk Score:
The target risk score of 16 reflects the actions and processes planned and controls in place to help mitigate the risk.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
* There is an annual programme of replacement in place for equipment, IT and Estates which follows a prioritisation process. * The People, Planning & Performance Committee (PPPAC) and Capital Estates & IM&T Sub Committee (CEIM&T) (to date with IM membership and wide stakeholder engagement in prioritisation process), receive reports and recommendations on the prioritisation and allocation of available capital. *Development of Programme Business Case (PBC) for the implementation of Health and Care Strategy which includes the development of business cases for a new build and repurposing of GGH and WGH sites, this is aligned to the Major Infrastructure Programme Business Case for business continuity on existing sites. * When possible, aligning replacement equipment to large All Wales Capital schemes to minimise the impact on discretionary capital within the UHB. * Completion of the medical devices inventory by the operational management team which helps in the prioritisation of available funds. * Retention of a medical equipment capital contingency to manage urgent issues of repair or replacement. * Review of regulatory reports which have a capital component ie. HIW, WAO, CHC. * Investigating the potential for 'Charitable' funding rather than Discretionary Capital Programme as appropriate. * Communication with Welsh Government via Planning Framework and IMTP (Infrastructure & Investment Enabling Plans) and regular dialogue through Capital Review meetings. * The impact of Covid19 recovery plans on capital requirements for 2021/22 need to be understood for their impact on All Wales Capital and it's impact on the 2021/22 DCP. * Preparation of priority lists for equipment, Estates and IM&T in the event of notification of additional capital funds from Welsh Government i.e. in year slippage and to enable where possible, the preparation of forward plans. This is also addressed through the identification of high priority issues through the annual planning cycle.	Capital funding is significantly short of the level required to deal with backlog maintenance programme for estates, digital & equipment. Impact that COVID recovery may have on the requirement for Capital Resources. No approved funding to deliver the SOP for Digital Improvements.	Digital Bids have been forwarded to Welsh Government to access the £25m in capital and revenue funding available in 2019/20. This is intended however for innovation and the digital backlog issues contained in the PBC submitted to Welsh Government along with other UHBs in 2017 remains unresolved.	Thomas, Huw	Completed	Further digital allocations have been received in 2020/21.
		During 2020/21, the PBC for Major Infrastructure has been submitted to WG to address backlog issues across the UHB. Scrutiny Comments have been received by WG.	Elliott, Rob	Completed	Action complete- the UHB has completed all scrutiny returns with WG to their satisfaction.
		Diagnostic Imaging Priorities for the HB are the completion of the MRI replacement in WGH and CT replacements on all sites. HB has been asked to submit bids to WG for 2 highest priorities which are identified as 2nd CT in GGH and replacement in WGH.	Thomas, Huw	Completed	WGH MRI replacement is currently on site due for completion in June 2021. Bids have been submitted to WG for CT priority replacements 25th February 2021. WG decision on funding is awaited. Funding has been awarded for the two schemes in 2021/22.
		The annual submission of the Strategic Medical Device Replacement report to the CEIM&T Sub-Committee, and the additional investment made through COVID - 19 allocations has increased the number of medical devices in the organisation. Progression of a business case for funding to help address priority backlog areas remains a priority.	Davies, Lee	31/03/2022	It is likely that DCP funds will need to be supplemented through a bid for All Wales capital to support essential replacements for the future. Business case submission will be discussed further with WG.

* Reports to CE&IMT SC set out priorities for imaging equipment and established a much firmer baseline position in relation to medical devices backlog.		Major Infrastructure PBC to be considered at the WG Infrastructure Investment Board (IIB) on 24 June 2021.	Elliott, Rob	24/06/2021	The UHB will be in attendance at this Board to give a short presentation and answer any questions from members of the IIB. If supported the WG will be in a position to Endorse the PBC allowing the UHB to progress the delivery of the investment plan and discuss with WG the allocation of additional resources to appoint the relevant specialist support/Supply chain partners.

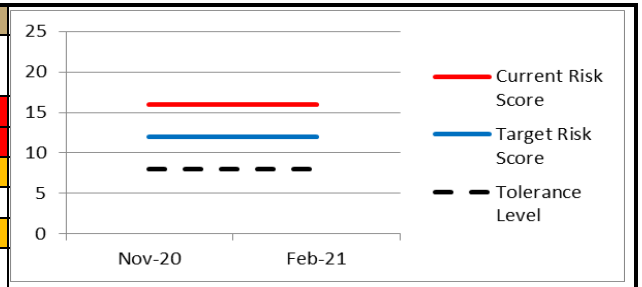
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance against plan & budget.	Reports of delivery against capital plan & budget	1st			* DCP and Capital Governance Report - PPPAC Apr 21 and CEIM&T Sub-Committee Mar 21 * DCP Report 2021/22 Executive Team Mar 21, CEIM&T Mar 21 and PPPAC Apr 21 * Radiology Equipment Risk CEIM&T Sub-Committee Jan 20 & Sep 20 * Strategic Medical Device Replacement					
	Capital Audit Tracker in place to track implementation of audit recommendations	1st								
	Monitoring returns to WG include Capital Resource Limit	1st								
	Datix & risk reporting at an operational management level	1st								
	PPPAC & CEIM&T Sub-Committee reporting (supported by sub-groups)	2nd								

Bi-monthly Capital Review Meetings with WG to discuss/monitor Capital Programme	2nd			CEIM&T Sub-Committee Jun 20 * Estate Infrastructure PPPAC Oct 20 and CEIM&T Sub-Committee Jul 20 * IM&T Infrastructure CEIM&T Sub-Committee Jul20				
NWSSP Capital & PFI Reports on capital audit	3rd							
WAO Structured Assessment 2017	3rd							

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Gostling, Lisa	**Date of Review:**	Feb-21
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Mar-21

Risk ID:	**1018**	**Principal Risk Description:**	There is a risk there will be insufficient workforce available to deliver services required for the quarter 3 and 4 plans. This is caused by an increase in Covid infections and outbreaks within acute, community and social care facilities which could lead to increased sickness absence directly due to COVID, increased self isolation of staff, and the ability to recruit new staff quickly to provide additional support. This could lead to an impact/affect on the Health Board's ability to staff field hospitals, surge capacity within general hospitals, effectively managing the impact from COVID outbreaks, delivering a mass vaccination programme and the delivery of planned care.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Workforce/OD
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	8
Trend:	⟺



Rationale for CURRENT Risk Score:
Given the workforce starting position in terms of gaps within our Registered Nursing workforce, increasing demands to open surge facilities, the current risk score is considered to be "likely" and has the potential to have a "major" impact. The result of an outbreak would see a significant number of key staff unavailable which would impact on service delivery and stretch service provision.

Rationale for TARGET Risk Score:
The Target Risk score indicates the likelihood of the risk occurring (and to note there have been minor outbreaks occurring weekly) which suggests this may continue, therefore the probability sits between 25-75% which we hope will be mitigated by the actions noted below.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Bronze, Silver & Gold Command structure, PPPAC Workforce Planning Task & Finish Group	An organisational wide escalation plan	Flexible deployment plans for each service area/and organisationally	Walmsley, Tracy	31/12/2020	Review of activity for areas ongoing by operational/professional and workforce leads i.e. Mass Vaccination, Field Hospitals , Scheduled care via different forums HON, Bronze structure & workforce planning activity by workforce planners now in post. To continue review within Bronze structure going forward. Scheduled care deployment activity took place Dec-Feb (now returning to "normal" posts. Further action as noted - review via WFP T&F.
		Ongoing onboarding of a flexible contingent workforce in areas of need i.e. cleanliness/infection control activity, fundamentals of care	Walmsley, Tracy	Completed	Continuous cycle of review and adapt based on assessed need. HON, workforce & bank teams aligned through HON meeting & central coordination by professional nurse leadership of resourcing pipeline for Mass Resourcing programme for COVID 2-6 (ongoing: to be met through current activity) Continue to review through WFP T&F
		Risk assessment of each service area based on workforce availability.	Walmsley, Tracy	Completed	Assessment of risk fed in through Bronze structure i.e. FH, Vaccine Programme etc. Historical workforce risks assessed via Datix and workforce planners sought assurance through professional leads as part of IMTP/education & commissioning process 2021. Continue to review through WFP T&F. Complete as at 10/02/21

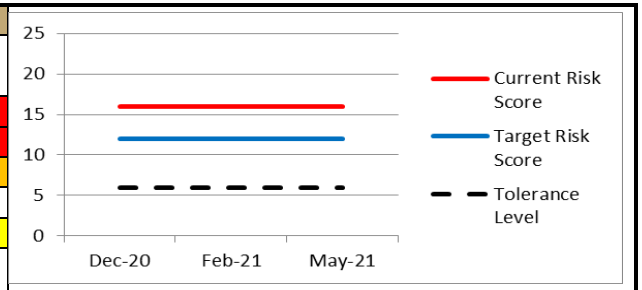
Assessment of corporate lead deployment options.	Walmsley, Tracy	Completed	Initial review of workforce available. Requires alignment to operational needs and risk assessments to be completed and signed off. Limited deployments of corporate leads. Although key roles covered in roles to support resourcing, mass vaccination etc Continue to review formal deployments through WFP T&F. Complete as at 10/02/21
Introduction of partnership agreement with key agencies to stabilise agency workforce to continue to fill establishment gaps	Walmsley, Tracy	31/12/2020	Work is underway to develop agreement for Pembrokeshire and Carmarthenshire.
Prioritisation of recruitment/onboarding of new employees to the highest areas of risk in terms of maintaining service delivery	Walmsley, Tracy	Completed	Weekly assessment of resourcing pipeline taking place within Workforce & OD Team. Continue to review through WFP T&F. Complete as at 10/02/21
Maximise use of temporary workforce availability to include Bank, Overtime and Agency	Walmsley, Tracy	Completed	Monthly assessment of resourcing pipeline taking place within Workforce & OD Team & specific assessments based on need undertaken. Continue to review through WFP T&F. Complete as at 10/02/21
NEW: Develop Annual Plan, IMTP for rest, recovery and reset of services; focusing on Workforce Plan alignment to predicted/possible scenario. Assess risk and develop mitigating actions for future plans. Learn Lessons form 2020/21 activity	Walmsley, Tracy	31/03/2021	IMTP/Workforce Plan due to People, Planning and Performance Assurance Committee

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
None identified.	Workforce Planning Task & Finish Group	1st					Undertake workforce planning audit	Walmsley, Tracy	Completed	Workforce Planning Audit undertaken through NWSSP. Substantial assurance given across all categories with any issues addressed.
	Workforce levels monitored at Bronze Workforce Group and reported to Silver and Gold	2nd								
	Workforce and Q3/Q4 plan overseen by People, Planning & Performance Assurance Committee	2nd								

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	May-21
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Jun-21

Risk ID:	**1027**	**Principal Risk Description:**	There is a risk there will be disruption to the delivery of our Q1 Recovery Plans. This is caused by increasing fragility within the urgent and emergency care (UEC) system, the impact of COVID-19 on available bed and staffing resources and delays in discharges that are beyond the remit of the Health Board. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increased incidents of a serious nature relating to ambulance handover delays at the front door and delayed ambulance response to community emergency calls, increasing pressure of adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators.
Does this risk link to any Directorate (operational) risks?		yes	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:

While case incidence of COVID-19 has regressed and its direct impact on acute care reduced, the level of risk escalation remains. The indirect impact of COVID-19 has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. As a consequence we continue therefore to have reduced availability of beds across acute sectors. This has reduced staffed bed availability across both sectors and has led to increasing delays in the discharge pathway and increasing delays for patients accessing unscheduled care services due to reduced capacity at ED departments. The situation remains fluid and changeable. This risk will be refreshed in Q2.

Rationale for TARGET Risk Score:

There is a significant challenge across the Urgent and Emergency Care system

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Comprehensive daily management systems in place to manage unscheduled care risks on daily basis including multiple daily multi-site calls in times of escalation. # Reviews of patients admitted to surged areas to ensure patient acuity and dependency is monitored and controlled. # Surge beds continue as per escalation and risk assessment of site demand and acuity (where staffing allows). A daily review of the use of surge beds via patient flow meetings to facilitate step down of beds. # Continued use of Field Hospital capacity. # Discharge lounge takes patients who are being discharged. # The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles. # Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites. # Regular training on discharge planning and complex care management is provided to ward based staff through Community Discharge Liaison teams, Social services and the Long Term Care Team support. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Escalation plans for acute and community hospitals (within limits of staffing availability). # Winter Plans developed to manage whole system pressures. # Joint workplan with Welsh Ambulance Services NHS Trust. # 111 implemented across Hywel Dda. # Transformation fund bids in relation to crisis response being implemented across the Health Board. # IP&C support for care homes to avoid outbreaks. # Care Home Risk and Escalation Policy. # Ability to deploy Health Board staff where workforce compromise is immediately threatening to continuation of care for residents. # Care Home risk & Escalation Policy to be applied to support failing care homes as required. # COVID-19 IP&C Outbreak policy in place to coordinate management of infection outbreaks, led by site HoNs (supported by IP&C teams). # Integrated whole system, cross-sector Winter Preparedness Plan agreed Oct20. # Establishment of a Discharge to Assess Group which reports to the Unscheduled Care group.	# Data has demonstrated that targeted improvement required across our UEC system to reduce conveyance, conversion and improve management of our Complex frail population and ensure enhanced 'front door' turnaround within max 72 hours and improved discharge coordination. # Fragility of Care Home Sector exacerbated by Covid related issues such as financial viability, increasing number of care home bed voids following outbreaks. # Fragility of Domiciliary care due to recruitment and retention of staff exacerbated by increased staff absences due to the TTP process. # Inability to secure GP medical oversight for step down/ intermediate care beds. # Inability to secure multidisciplinary resource to support discharge to assess model in the community. # Insufficient informatics support to enhance Complex Discharge caseload management tool. # Nurse staffing availability to ensure safe levels of care as a consequence vacancies and COVID 19 related absence across acute and community care. # Reduced acute bed availability due to impact of COVID-19 outbreaks and reduced staffing availability # COVID-19 has further exacerbated workforce capacity and availability of bank and agency staff who would be	To appoint HCSWs as supernummary aligned to the acute response teams to support failing community care capacity (secondary to COVID outbreak).	Dawson, Rhian	Completed	Appointed and in post.
		To consider alternative models of medical oversight i.e appointment of GP locums aligned to acute physicians	Dawson, Rhian	31/07/2021	Pending hibernation of Field Hospital will release medical oversight.
		Refer CRR 1018 detailing actions to address insufficient workforce to support delivery of essential services.	Gostling, Lisa	30/06/2021	Updated Workforce Plan to be reflected in refreshed Annual Plan due for submission June 2021.
		To appoint additional support to lead on enhancement/ implementation of the Complex Discharge caseload management tool (SharePoint).	Dawson, Rhian	Completed	Appointed.
		To remind services to of the need to undertake robust sickness absence management to ensure staff are able to return to work safely and promptly.	Jones, Keith	Completed	Actioned. Impact of updated shielding guidance continues to limit the return of affected staff.
		To encourage and support staff to participate in the UHB's Covid-19 vaccination programme.	Carruthers, Andrew	Completed	Actioned.
		To support asymptomatic testing pathfinders.	Carruthers, Andrew	Completed	LFT rolled out across targeted clinical areas (outbreak wards, Chemotherapy Day Units & selected planned care wards). Full rollout to priority groups be completed by May21.

# Establishment of a D2A Escalation Transfer panel which provides senior oversight of delays, assesses risk of the delay to the patient and organisation in terms of flow compromise	available.	Each County System to produce UEC Improvement plans Implementation of Programme Management Structure in UEC Improvement Secure UEC Transformation fund to resource key deliverables that will enhance improvement capability	Dawson, Rhian	31/07/2021	Bid Submitted. Programme Management Structure to be agreed and implemented.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**		
Performance indicators for Tier 1 targets. A suite of unscheduled care metrics have been developed to measure the system performance.	Medically optimised and ready to transfer patients are reported 3 times daily on situation reports	1st			
	Daily performance data overseen by service management	1st			
	Delivery Plans overseen by Unscheduled Care Improvement Programme	2nd			
	Bi-annual reports to PPPAC on progress on delivery plans and outcomes (and to Board via update report)	2nd			
	Fortnightly monitoring of Winter Plan 2020 delivery.	2nd			
	IPAR Performance Report to PPPAC & Board	2nd			

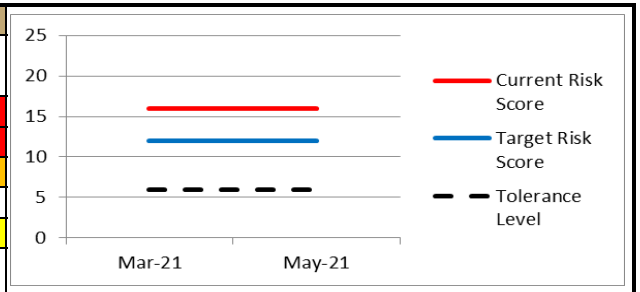
Gaps in ASSURANCES				
Identified Gaps in Assurance:	**How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
None identified.				

WAST IA Report Handover of Care	3rd								
11 x Delivery Unit Reviews into Unscheduled Care	3rd								
Delivery Unit Report on Complex Discharge	3rd								

Date Risk Identified:	Mar-21	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	May-21
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Jun-21

Risk ID:	**1048**	**Principal Risk Description:**	There is a risk there will be disruption to the delivery of planned care services set out in the Annual Recovery Plan 2021/22. This is caused by , in the short term, the legacy of the impact of the 2nd wave on available capacity and a continuing significant deficit in available staffing resources to support green pathways for urgent and cancer pathway patients. These pressures have necessitated the HB to apply the WG Local Options Framework of actions to prioritise resources for COVID and other essential emergency pathways. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increasing pressure of adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6
Trend:	⇔



Rationale for CURRENT Risk Score:

While case incidence of COVID-19 has regressed and its direct impact on acute care reduced, the level of risk escalation remains.

Limits to staffing resource both in theatre, and post operatively, was a challenge before COVID. The additional factors of providing separate staffing teams for red and green areas, is an added challenge and has shaped the model of provision suggested on each site. It is evident that our realisable capacity in the short term will not match that available prior to Mar20. The plans we have outlined do however reflect the maximum capacity we can achieve within the footprint of our existing hospital sites, particularly during the first half of 2021.

Whilst the plan for increased delivery of elective work (outlined within the HDUHB Annual Plan) is progressing in accordance with the plan outlined, challenges and risks around availability of supporting bed and theatre capacity remain which limits the ability of our clinical teams to expand activity delivery to pre-COVID levels, and further waves of the pandemic.

Rationale for TARGET Risk Score:

Across the UK, there is a significant challenge for health organisations in sustaining the recovery of planned care pathways as they emerge from the 2nd wave of the pandemic. The target score of 12 is based on the realistic assessment of the level of planned care work which can be achieved across the footprint of the HB over the next 12 months and acknowledges this will not reflect levels achieved pre-pandemic due to the current staffing challenge and the impact on capacity and throughput of expected requirements to maintain social distancing and enhanced IP&C procedures.

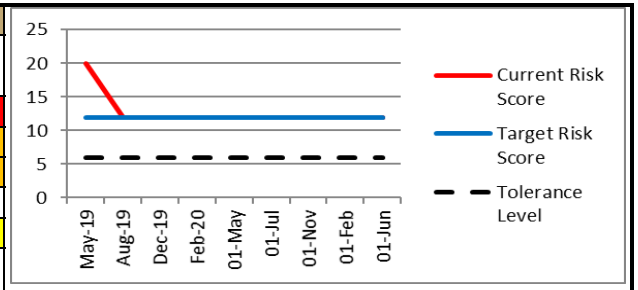
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Comprehensive daily management systems in place to manage planned care risks on daily basis including multiple daily multi-site calls in times of escalation. # Prioritised review of patients based on an agreed risk stratification model. # Provision of 'green' pathway beds on 4 sites (where staffing allows). # Discharge lounge takes patients who are being discharged. # The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Escalation plans for acute and community hospitals (within limits of staffing availability). # Outpatient transformation programme in place with a continuing focus on alternatives to face to face delivery of outpatient care to enable increases in care volumes delivered. # Risk assessed establishment of AMBER post-operative critical care pathway as a more practical alternative to dedicated GREEN post-operative critical care pathway to increase the flow of appropriate patients. # Robust sickness absence management arrangements in place.	# Nurse staffing availability to ensure safe levels of care as a consequence vacancies and COVID 19 related absence across ward, critical care and theatre areas # Reduced acute bed availability due to impact of COVID-19 outbreaks and reduced staffing availability # COVID-19 has further exacerbated workforce capacity and availability of bank and agency staff who would be available. # Limitations of the physical estate on hospital sites to enable protected/dedicated green pathway critical care facilities	Plan for Q1 & Q2 levels of capacity to be agreed via 2021/22 Annual Plan	Jones, Keith	Completed	Initial plan completed March 2021. Updated plan to be reflected in refreshed Annual Plan to be submitted June 2021.
		Opportunities to enhance dedicated green pathway capacity across sites are subject to continuous review and discussion between respective acute sites and Planned Care Directorate	Jones, Keith	Completed	Green pathways re-established on 4 sites.
		Refer CRR 1018 detailing actions to address insufficient workforce to support delivery of essential services.	Gostling, Lisa	30/06/2021	Updated Workforce Plan to be reflected in refreshed Annual Plan due for submission June 2021.
		Assistant Director of Nursing (Acute Services) leading a review of overall acute nurse staffing resource availability with support from acute site and directorate heads of	Jones, Keith	Completed	Staffing deficits confirmed. Current delivery progressing in accordance with available staffing.
		To remind services to of the need to undertake robust sickness absence management to ensure staff are able to return to work safely and promptly	Jones, Keith	Completed	Actioned however impact of updated shielding guidance continues to limit the return of affected staff.
		Planned Care Recovery programme to be formally established within HB, setting out governance arrangements at Gold, Silver and Bronze levels.	Jones, Keith	31/07/2021	Initial recovery proposals approved by WG with additional funding support confirmed. Delivery Plan for Planned Care Recovery Programme
		To support routine testing of staff	Carruthers, Andrew	Completed	LFT rolled out across selected planned care wards and clinical areas.
		Development of ward based post operative enhanced care pathways as an alternative to dedicated green critical care facilities.	Jones, Keith	31/05/2021	Implemented at PPH. Development continuing at other sites, timelines dependent on staffing availability.
		Development of plans to enhance capacity through consideration of demountable facilities and opportunities to develop regional solutions for key pathways (eg cataract surgery).	Jones, Keith	Completed	Proposal submitted to WG April 2021. Non-recurrent funding for 2021/22 confirmed by WG. Formal proposal due to be considered by Board July 2021.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance indicators for Tier 1 targets. A suite of planned care metrics have been developed to measure the system performance.	Activity volumes are reported daily on situation reports	1st				None identified.				
	Daily performance data overseen by service management	1st								
	Delivery Plans overseen by Acute Services Triumvirate	1st								
	Bi-monthly reports to PPPAC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	Fortnightly monitoring of Winter Plan 2020 delivery	2nd								
	IPAR Performance Report to PPPAC & Board	2nd								

Date Risk Identified:	May-17	**Executive Director Owner:**	Thomas, Huw	**Date of Review:**	Jun-21
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Aug-21

Risk ID:	**451**	**Principal Risk Description:**	There is a risk the Health Board experiencing a cyber security breach. This is caused by a lack of defined patch management policy, lack of management on non-ICT managed equipment on network, end of life equipment no longer receiving security patching from the software vendor, lack of software tools to identify software vulnerabilities and staff awareness of cyber threats/entry points. This could lead to an impact/affect on a disruption in service to our users cause by the flooding of our networks of virus traffic, loss of access to data caused by virus activity and damage to server operating systems.
Does this risk link to any Directorate (operational) risks?		451, 356	

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	3×4=12
30/05/2019 - Board 'Accept' Target Risk	
Tolerable Risk:	6
Trend:	⟺



Rationale for CURRENT Risk Score:

There are daily threats to systems which are managed by NWIS and UHB. Current patching levels within the UHB of is on average 94% for desktop/laptops and 91% for the server infrastructure (May 2021). The patching levels fluctuate during the month depending on the number of updates released by the 3rd party vendor. Alongside the fluctuations there is lack of capacity to undertake this continuous work at the pace required. Impact score is 4 as a cyber-attack has the potential to severely disrupt service provision across all sites for a significant amount of time, however the processes and controls in place have reduced the likelihood due to the improvements in patching.

Rationale for TARGET Risk Score:

Increased patching levels will help to reduce to impact of disruption from a cyber threat. However this work is continuous and is dependent on obtaining the appropriate level of resources to undertake the patching anti-virus work at pace. The target risk score of 12 reflects the wider risk to other applications not Microsoft. The Board have accepted that there is an inherent cyber risk to the organisation, and have therefore accepted that the risk cannot be reduced lower than 12.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Controls have been identified as part of the national Cyber Security Task & Finish Group. Continued rollout of the patches supplied by third party companies, such as Microsoft, Citrix, etc. £1.4m national investment in national software to improve robustness of NWIS. Further Task and Finish Group established to review the future patching arrangements within NHS Wales - this will lead future work locally to implement recommendations. Capital funding has been made available by WG in 2018/19 to improve cyber security - this will be used to purchase required software/equipment for penetration testing. Additional UHB funding.	Lack of comprehensive patching across all systems used in UHB. Lack of staffing capacity to undertake continuous patching at pace. Lack of dedicated maintenance windows for updating critical clinical systems.	Work with system owners to arrange suitable system down-time or disruption.	Solloway, Paul	Ongoing	Patching policies have been created however little progress has been made due to lack of resources. Service catalogue creation is progressing well and this will be amalgamated with Information Asset Owners group to agree down-time for the key local systems. However patching KPI's will not be met until sufficient technical resources are in place.
		Continue to implement the recommendations of the Stratia report	Solloway, Paul	Ongoing	The additional resources will be targeted towards the recommendations
		Implement the national products previously purchased (i.e. Security Information Event Management (SIEM)	Solloway, Paul	Ongoing	The additional resources will be targeted towards the recommendations
		Hire agency staff until such time that a permanent resource can be appointed.	Tracey, Anthony	Completed	The first round of appointments did not provide suitable candidates so agency staff will be used to provide progression of the recommendations.
		Appoint a dedicated cyber resilience resource to take forward the recommendations outlined within the Stratia report, and the recent Audit Wales Report, presented to ARAC.	Tracey, Anthony	Completed	The New Cyber Resource began in May 2021, and is in the process of addressing the Stratia report, and developing a Cyber Resilience Plan. The Digital Team, have also contracted with a third party company to work with us to develop our Cyber Resilience Plan

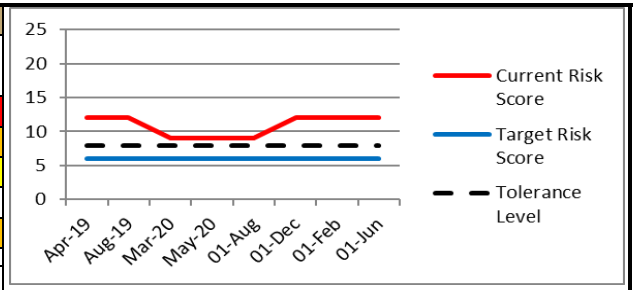
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
No of cyber incidents. Current patching levels in UHB. No of maintenance windows agreed with system owners. Removal of legacy equipment.	Department monitoring of KPIs	1st			External Security Assessment - IGSC - Jul 18 Update on WAO IT follow-up - ARAC - Oct19	National accreditation.	Progress the attainment of certificates and assurances as outlined by the National Cyber Security Centre (NCSC)	Tracey, Anthony	Ongoing	Regular reports on progress on External assessment to IGSC
	IGSC monitoring of cyber security workplan addressing recent internal and external audits/assessments	2nd								
	IGSC monitoring of National External Security Assessment	2nd								
	Follow-up Information Backup, Disaster Recovery & Business Continuity and Data Quality: Update on Progress	3rd								
	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB) Oct17	3rd								
	WAO IT risk assessment (part of Structured Assessment 2018	3rd								
	Internal Audit IM&T Security Policy & Procedures Follow-Up - Reasonable Assurance	3rd								

IM&T Assurance - Follow Up - Reasonable Assurance - May20	3rd							
Cyber Security (Stratia Report) - Reasonable Assurance - Feb20	3rd							

Date Risk Identified:	Sep-18	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Jun-21
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Aug-21

Risk ID:	**633**	**Principal Risk Description:**	There is a risk of the UHB not being able to meet the 75% target for waiting times for 2020/21 for the new Single Cancer Pathway (SCP). This is caused by the lack of capacity to meet expected increase in demand for diagnostics and treatment delays at our tertiary centre. This could lead to an impact/affect on meeting patient expectations in regard to timely access for appropriate treatment, adverse publicity/reduction in stakeholder confidence and increased scrutiny/escalation from WG.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	3×2=6
Tolerable Risk:	8
Trend:	⟺



Rationale for CURRENT Risk Score:

The impact of COVID-19 may increase the risk of being unable to meet the target due to recommendations from Royal Colleges to suspend diagnostics and some surgery that are aerosol generating. During the pandemic, endoscopy was centralised in GGH. Endoscopy services were reinstated on all 4 hospital sites, with capacity increasing to 53%. With the introduction of a Green pathway in Endoscopy as of 7th June 21, capacity will increase to 81%. High acuity elective cancer surgery with green pathway and green ITU/HDU commenced in PPH & BGH on 6 July 2020 with WGH commencing intermediate surgery on the 10 Aug 2020. Following the second wave of COVID in December, all green HDU/ITU pathways have been reinstated and the surgical backlog has been addressed. A full Covid-19 plan is in place.

Rationale for TARGET Risk Score:

The aim is to treat patients within target waiting times, which has now been confirmed as 75% for the first year, 80% for the 2nd year and 85% thereafter non adjusted. Due to the pause in Cancer elective surgery over the Christmas period for a 4 weeks , there was no HDU/ITU green pathway available, caused a surgical backlog for cancer surgery. This backlog has now been addressed.
The tolerance level will be met if the UHB continues to meet the 1% per month improvement trajectory throughout 2021/22. Publication of performance data by WG recommenced in February 2021 with health boards only reporting against the SCP, with no wait adjustment.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Working with all Wales Cancer Network to gain full understanding of implications of new pathway. Implementation Group established, reporting to Cancer Board with awareness / engagement sessions held on each hospital site. Shadow monitoring in place. Further Demand & Capacity exercise planned 2020/21 with support from Delivery Unit. New Cancer tracking module in W-PAS now fully operational as of Dec19 with tracking team in place from Dec19 to allow patients to proactively tracked through treatment pathways. Routine daily communication feed from ED to cancer information team which helps identify the point of suspicion. COVID-19 escalation plan in place. Monitoring data of patients whose treatments have changed or suspended (some through patient choice) as a result of COVID-19. A 4-week follow up process has been implemented for these. Utilisation the private sector for surgery during COVID-19. Joint working with regional colleagues to offer patients on a tertiary pathway surgery locally. Resumed aerosol generated diagnostics cross all 4 hospital sites. Due to the current COVID situation, these services are now being scaled back with Endoscopy services being mainly centralised in GGH.	Anticipated significant gaps within key diagnostic services to address required levels of activity to support SCP. Full engagement for all supporting services. Performance is lower than USC/NUSC published performance. Key diagnostic information systems do not support effective demand / capacity planning. Need for new, streamlined optimal clinical pathways to reduce diagnostic demand and expedite assessment pathways.	Demand & capacity assessment work continuing. Solutions will necessitate regional cooperation to address anticipated capacity gaps.	Humphrey, Lisa	~~31/03/2020~~ ~~31/03/2021~~ 31/12/2021	Initial planned work with Delivery Unit suspended and will be under constant review in light of COVID and recovery planning phase. Work is ongoing .
		See above re diagnostic services plus improved systems to support identification of 'date of suspicion'.	Humphrey, Lisa	~~31/03/2019~~ ~~31/08/2019~~ ~~31/07/2020~~ ~~31/10/2020~~ ~~31/03/2021~~ 31/08/2021	HB performance compares well with other HBs however below current SCP performance level. Ongoing work in progress with OPD, Diagnostic & ED teams along with the informatics department to improve real time identification of date of suspicion. Informatics are beginning to pick up routine reporting requests which were on hold due to COVID-19.
		Each MDT to review and adopt recommended optimal tumour site specific pathways	Humphrey, Lisa	~~31/08/2020~~ ~~30/09/2020~~ ~~31/03/2021~~ 31/12/2021	Each MDT is currently assessing implications of published proposed pathways. A Macmillan Cancer Quality Improvement Manager post which was developed to work with the teams with regards to implementing the new pathways has been appointed to and the new appointee took up post on 1st November 2020. Agreement over funding was delayed as a result of COVID-19.

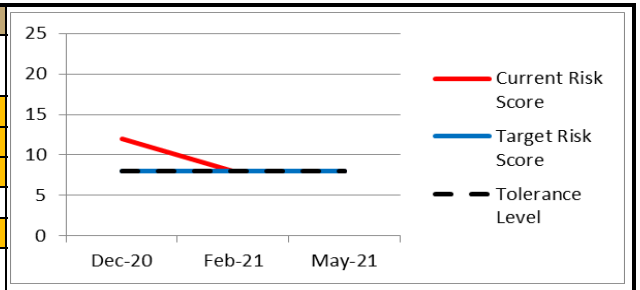
Reinstated high acuity elective Cancer surgery with green pathway and green ITU/HDU has commenced on PPH and BHG sites as of 06/07/2020, and WGH Intermediate surgery from 10/08/20. Due to the current COVID situation, only urgent cancer elective surgery will be carried out from the 21st December for a period of 4 -6 weeks due to staffing levels. All patient are being clinically prioritised to ensure no harm is caused by the delay. 7 Day Diagnostic Group and RDC. FIT and Digital Delivery of Care.		Explore opportunities for alternative providers to address tertiary centre delays for cancer treatment.	Humphrey, Lisa	Completed	Some arrangements were agreed however these have been suspended due to COVID-19, however COVID has provided opportunities to enable new arrangements to be put in place with regional centres.
		The HB will offer FIT test to appropriate cancer patients to reduce the need for endoscopy.	Humphrey, Lisa	31/12/2021	FIT commenced in May 2020 and is ongoing
		Provide virtual consultations to cancer patients where appropriate, to increase access to cancer services.	Humphrey, Lisa	31/12/2021	This commenced in May and is ongoing.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Deliverable indicator targets - 1% improvement per month during 2020/21. Shadow performance data.	Daily/weekly/monthly/ monitoring arrangements by management	1st			* Implementation of Single Cancer Pathway Report - BPPAC - Feb20 * IPAR Report - Board - Jan21 * COVID-19 Impact on Cancer Services - Board - May20 * Cancer Updated to QSEAC Jun20 & OpQSESC Jul20 * Risk 633 QSEAC - Feb21	No gaps identified.				
	Executive Performance Reviews (suspended due to COVID-19)	2nd								
	Service plans in response to COVID-19 overseen and agreed by Bronze Acute & Gold	2nd								
	IPAR Performance Report to PPPAC & Board	2nd								
	Monthly oversight by Delivery Unit, WG	3rd								

Date Risk Identified:	Dec-20	**Executive Director Owner:**	Jervis, Ros	**Date of Review:**	May-21
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Jul-21

Risk ID:	**1030**	**Principal Risk Description:**	There is a risk to the Health Board's reputation should there be a perception that the HB does not have a coherent and/or deliverable plan for the COVID-19 Vaccination Programme. This is caused by significant and ever changing vaccine policy requirements, delivery parameters such as workforce requirements and vaccination supplies in overall doses and vaccine type. This could lead to an impact/affect on a reduction in stakeholder confidence, increased scrutiny from the local community, the media, regulators and WG increasing pressure to deliver on all aspects of the programme, at pace, whilst competing with other Health Board priorities and operational challenges.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Adverse publicity/reputation
Inherent Risk Score (L x I):	3×4=12
Current Risk Score (L x I):	2×4=8
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:
The Board have approved the Mass Vaccination Delivery Plan, which addressed many of the previously articulated gaps in control. The plan is progressing at pace and is being managed by the Bronze Vaccination Delivery Group and overseen by the Silver Tactical Group. As we move through the programme, achieving each milestone we continue to manage programme delivery despite regular advice and policy changes within the context of unpredictable and inconsistent vaccine supplies.

Rationale for TARGET Risk Score:
As the programme delivery embeds, and initial uncertainties settle and knowledge/understanding of each vaccine and their individual characteristics improve. Expectations of individuals within our workforce and our communities will be better understood and supported over time.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Director of Public Health and Vaccination Programme Leads have a direct link with COVID -19 National Board (stakeholder and operational level). Command & control structures in place. Bronze Vaccine Delivery Group. Board approved Mass Vaccination Delivery Plan, including communications strategy. Continued support at national level via NWIS and internal IT colleagues. 4-week Forward Plan of Predicted Vaccine Supplies. Full functionality of national WIS (Welsh Immunisation System) to facilitate call/recall service to ensure prioritised groups are vaccinated first. This requires our local call centre to be within the Command Centre. Dedicated security arrangements in place.	Lack of control of volumes of vaccine by type. Changeable advice and guidance on vaccination. Competing COVID and non-COVID priorities across all services in respect of workforce. Lack of control on future use/changes of external venues.	Awaiting confirmation of vaccine delivery schedule to inform planned programme roll out.	Jervis, Ros	Completed	4 week forward predicted plan in place.
		Future meeting with external partners agencies to look at risks associated with external venues.	Jervis, Ros	Completed	Ongoing dialogue with key partners and scoping of possible venues underway.

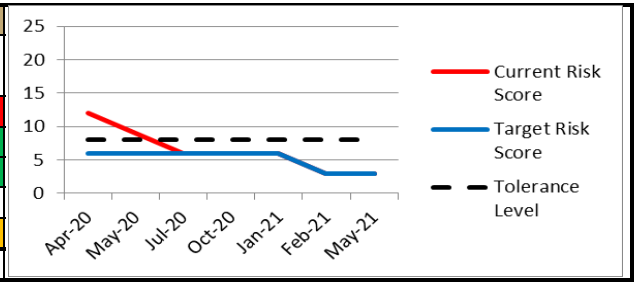
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance** **(1st, 2nd, 3rd)**	**Required Assurance** **Current Level**			**Identified Gaps in Assurance:**	**How are the Gaps in ASSURANCE will be addressed** **Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
Regular reporting of progress and position to National Covid Vaccine Board (CVB).	Regular reporting into Hywel Dda Tactical (Silver) Group	2nd				None identified.	To complete Internal Audit review of Hywel Dda Vaccination Programme	Jervis, Ros	Completed	Internal audit review undertaken and presented to ARAC.
	Regular updates to Executive Team and Integrated Executive Group (RPB)	2nd								

Regular reporting into Dyfed Powys Local Resilience Forum	2nd						
Core member of, and regular reporting to (including daily sitreps), the National Covid Vaccine Delivery Board (CVB)	2nd						
Mass Vaccination Programme IA advisory report (Apr21)	3rd						

Date Risk Identified:	Apr-20	**Executive Director Owner:**	Moore, Steve	**Date of Review:**	May-21
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Jul-21

Risk ID:	**854**	**Principal Risk Description:**	There is a risk that UHB's response to COVID-19 proves to be larger than needed for actual demand. This is caused by incorrect modelling assumptions or changes in the progression of the pandemic. This could lead to an impact/affect on abortive costs and possible reputational damage.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Adverse publicity/reputation
Inherent Risk Score (L x I):	5×3=15
Current Risk Score (L x I):	1×3=3
Target Risk Score (L x I):	1×3=3
Tolerable Risk:	8
Trend:	



Rationale for CURRENT Risk Score:

Likelihood recognises that limits to our ability to grow our bed base reduce the risk of over capacity and our modelling is informing the scale of gap. It also reflects revised planning assumptions from Welsh Government (WG) for winter COVID-19 demand which will be close to available Field Hospital capacity. The WG funding process for COVID-19 has been clarified and our current forecast out turn is in line with pre-covid plans at £25m.Likelihood further reduced in light of the growing certainty of achieving our year end financial target.

Rationale for TARGET Risk Score:

Planning has been based on current planning assumptions and the Public Health Plan being effective. Target risk score has been met.

Key CONTROLS Currently in Place:
(The existing controls and processes in place to manage the risk)

Modelling cell established to provide regular updates on planning numbers, linked into the Welsh Government modelling group and other Health Boards.

Welsh Government direction to risk over provision rather than under provision will limit reputational damage.

All developments subject to a business case approach to ensure value for money is considered alongside other issues.

Board oversight and sign off of decision-making at all levels of the Command Structure.

Gaps in CONTROLS

Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**

Good Communications with Community Health Council, local politicians and Local Authorities. Regular media engagement (internal/external). Revised Strategic Planning Requirements Directive from Gold to Tactical on 27/04/20 includes field hospitals available as alternative sites. WG informed of COVID-19 related costs on regular basis. Financial Framework/Business Case approval process in place and the Finance Committee is providing assurance to Board.						

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Delivery of £25m deficit at year end.	Response to COVID-19 reviewed through Command and Control Structure	2nd			Responding to the COVID-19 Pandemic - Board - Apr20, May20, Jun20, Jul20, Sep20, Nov20, Jan21, Mar21, May21 Finance Report Month M012 - FC - May21 Q1 Covid-19 Costs - FC - May20					
	Board oversight of Response to COVID-19	2nd								
	Finance Committee (FC) review of COVID-19 costs as part of monthly finance report	2nd								
	WG support (to date) of UHB response to COVID-19	3rd								
	KPMG Review of Field Hospital Provision - Sep20	3rd								
	AW Structured Assessment 2020	3rd								

RISK SCORING MATRIX

Likelihood x Impact = Risk Score					
Likelihood	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	**This will probably never happen/recur (except in very exceptional circumstances).**	**Do not expect it to happen/recur but it is possible that it may do so.**	**It might happen or recur occasionally.**	**It might happen or recur occasionally.**	**It will undoubtedly happen/recur, possibly frequently.**
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least weekly.*	Expected to occur at least daily.*
	* time-framed descriptors of frequency				
Probability - Will it happen or not? (what is the chance the adverse consequence will occur in a given reference period?)	**(0-5%*)**	**(5-25%*)**	**(25-75%*)**	**(75-95%*)**	**(>95%*)**
	*used to assign a probability score for risks related to time-limited or one off projects or business objectives.				
Risk Impact Domains	**Negligible - 1**	**Minor - 2**	**Moderate - 3**	**Major - 4**	**Catastrophic - 5**
Safety of Patients, Staff or Public	**Minimal injury requiring no/minimal intervention or treatment.**	**Minor injury or illness, requiring minor intervention.**	**Moderate injury requiring professional intervention.**	**Major injury leading to long-term incapacity/disability.**	**Incident leading to death.**
	No time off work.	**Requiring time off work for >3 days**	**Requiring time off work for 4-14 days.**	**Requiring time off work for >14 days.**	**Multiple permanent injuries or irreversible health effects.**
		Increase in length of hospital stay by 1-3 days.	**Increase in length of hospital stay by 4-15 days.**	**Increase in length of hospital stay by >15 days.**	**An event which impacts on a large number of patients.**
			Agency reportable incident.	**Mismanagement of patient care with long-term effects.**	
			An event which impacts on a small number of patients.		
Quality, Complaints or Audit	**Peripheral element of treatment or service suboptimal.**	**Overall treatment or service suboptimal.**	**Treatment or service has significantly reduced effectiveness.**	**Non-compliance with national standards with significant risk to patients if unresolved.**	**Totally unacceptable level or quality of treatment/service.**
	Informal complaint/inquiry.	**Formal complaint.**	**Formal complaint -**	**Multiple complaints/ independent review.**	**Gross failure of patient safety if findings not acted on.**
		Local resolution.	**Escalation.**	**Low achievement of performance/delivery requirements.**	**Inquest/ombudsman inquiry.**
		Single failure to meet internal standards.	**Repeated failure to meet internal standards.**	**Critical report.**	**Gross failure to meet national standards/performance requirements.**
		Minor implications for patient safety if unresolved.	**Major patient safety implications if findings are not acted on.**		
		Reduced performance if unresolved.			

Workforce & OD	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff.	Uncertain delivery of key objective/service due to lack of staff.	Non-delivery of key objective/service due to lack of staff.
			Unsafe staffing level or competence (>1 day).	Unsafe staffing level or competence (>5 days).	Ongoing unsafe staffing levels or competence.
			Low staff morale.	Loss of key staff.	Loss of several key staff.
			Poor staff attendance for mandatory/key training.	Very low staff morale. No staff attending mandatory/ key training.	No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
		Reduced performance levels if unresolved.	Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty.	Prosecution.
				Improvement notices.	Complete systems change required.
				Low achievement of performance/delivery requirements.	Low achievement of performance/delivery requirements.
				Critical report.	Severely critical report.
Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage
					Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.

RISK MATRIX

IMPACT ↓	LIKELIHOOD →				
	RARE	UNLIKELY	POSSIBLE	LIKELY	ALMOST CERTAIN
	1	2	3	4	5
CATASTROPHIC 5	5	10	15	20	25
MAJOR 4	4	8	12	16	20
MODERATE 3	3	6	9	12	15
MINOR 2	2	4	6	8	10
NEGLIGIBLE 1	1	2	3	4	5

RISK ASSESSMENT - FREQUENCY OF REVIEW

RISK SCORED	DEFINITION	ACTION REQUIRED (GUIDE ONLY)	MINIMUM REVIEW FREQUENCY
15-25	Extreme	Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have an effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required.	This type of risk is considered extreme and should be reviewed and progress on actions updated, at least monthly.
8-12	High	Very unlikely to be acceptable. Significant resources may have to be allocated to reduce the risk. Urgent action should be taken. A number of control measures may be required.	This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly.
4-6	Moderate	Not normally acceptable. Efforts should be made to reduce risk, providing this is not disproportionate. Establish more precisely the likelihood & harm as a basis for determining the need for improved measures.	This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months.
1-3	Low	Risks at this level may be acceptable. If not acceptable, existing controls should be monitored & reviewed. No further action or additional controls are required.	This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually.