Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	07 December 2023
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Corporate Risks Assigned to the Quality, Safety and Experience Committee (QSEC)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Director of Operations Jill Paterson, Director of Primary Care, Community & Long Term Care Ardiana Gjini, Director of Public Health
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Wilson, Director of Corporate Governance Charlotte Wilmshurst, Assistant Director of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

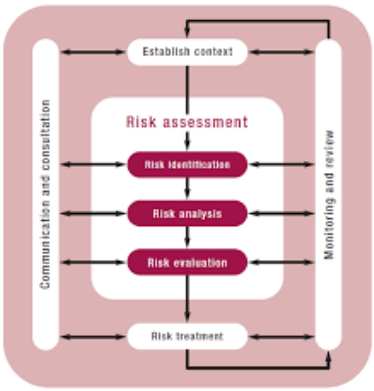
ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Quality, Safety and Experience Committee (QSEC) 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 risks within their remit. They are responsible for:

- Seeking assurance on the management of risks on the Corporate Risk Register (CRR) and providing assurance to the Board that risks are being managed effectively and report areas of significant concern, for example, where risk appetite is exceeded, lack of action, etc.

- Reviewing operational risks over tolerance and, where appropriate, recommend the 'acceptance' of risks that cannot be brought within Hywel Dda University Health Board's (HDdUHB) risk appetite/tolerance to the Board.
- Identity through discussions any new/emerging risks and ensure these are assessed by management.
- Signpost any risks outside of its remit to the appropriate HDdUHB Committee.
- Use risk registers to inform meeting agendas.

These risks have been identified by individual Directors via a top-down and bottom-up approach and are either:

- Associated with the delivery our annual plan; or
- Significant operational risks escalated that 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 consideration the gaps, planned actions, and agreed tolerances, and to provide assurance to the Board through their 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 consideration 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 regarding 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.

The process for risk reporting and monitoring within the UHB is outlined at Appendix 1.

Asesiad / Assessment

The QSEC Terms of Reference reflect the Committee's role in providing assurance to the Board that principal risks are being managed effectively by the risk owners (Executive Leads).

The Terms of Reference state that:

3.2 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.

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

3.4 Receive assurance through Sub-Committee Update Reports that risks relating to their areas are being effectively managed across the whole of the UHB's activities (including for hosted services and through partnerships and Joint Committees as appropriate).

There are 9 risks currently aligned to QSEC (out of the 20 that are currently on the CRR) as the potential impacts of the risks relate to the safety of patients, quality of services and patient outcomes. A summary of corporate risks can be found at Appendix 2.

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. These can be found at Appendix 3.

Changes since the previous report to QSEC (August 2023):
The Committee is requested to seek assurance from risk owners (Executive Directors) that each risk is being managed effectively and will be brought within the UHB tolerance.

Below is a summary of changes since the previous report to QSEC:

Total Number of Open Risks	9	
New Risks Being Reported	2	*See note 1*
De-escalated/Closed Risks	2	*See note 2*
Increase in Risk Score ↑	4	*See note 3*
Reduction in Risk Score ↓	0	
No Change in Risk Score →	3	*See note 4*

The 'heat map' below includes the risks currently aligned to QSEC:

HYWEL DDA RISK HEAT MAP					
	LIKELIHOOD →				
IMPACT ↓	**RARE 1**	**UNLIKELY 2**	**POSSIBLE 3**	**LIKELY 4**	**ALMOST CERTAIN 5**
CATASTROPHIC 5					1699 (↑)
MAJOR 4				684(↑) 1708 (NEW)	797 (→) 1027(→) 1032 (→) 1531 (↑) 1664 (NEW)
MODERATE 3				1548 (↑)	
MINOR 2					
NEGLIGIBLE 1					

Note 1- New risks being reported:
Since the previous report, 2 new risks have been added to the Corporate Risk Register.

Risk Reference & Title	Date risk identified	Lead Director	Current risk score	Update	Target Risk Score
1664 - Risk to Ophthalmology	23/05/23	Director of Operations	**4×5=20** (Reviewed 19/10/23)	Increased demand and reduced capacity are a	**2x5=10**

service delivery due to a national shortage of Consultant Ophthalmologists and the inability to recruit NEW				continuing challenge. Balancing Eye Care Measures for patients most at risk, with Ministerial Measures for longest waiting patients, presents a conflicting priority to the service with limited capacity. The service has provided additional Age-Related Macular Degeneration (AMD) sessions on a weekend; however, these additional sessions have not been enough to meet the demand across all counties in the Health Board. Patient delays continue across the Health Board. AMD continues to be prioritised, impacting on the provision of general clinics, having an impact on the wider Ophthalmology service and patient experience. The current non-medical workforce establishment is not aligned to service needs. Additional staffing for Wet Age-Related Macular Degeneration was incorporated into the Integrated Medium-Term Plan (IMTP) however no funding was allocated. The service currently has 5713 patients that have been 100% delayed for their follow up appointment. The total 'new patient' referrals are currently at 5492, of which 403 are breaching 52 weeks (the longest wait from this cohort is 67 weeks). 3785 patients are currently awaiting an Ophthalmic operation, of	

				which 24 are breaching 104 weeks (the longest wait from this cohort is 120 weeks). The 'Current Impact' has been scored as 5 because patients suffering irreversible sight loss or damage is a reality. The 'Current Likelihood' has been scored as 5 as Ophthalmology is a fragile service. It is unlikely that we will be able to achieve the Board Tolerance Score of 6 without a regionally agreed solution.	
1708 - Risk of increasing fragility in Primary Care Contractor services due to recruitment challenges NEW	07/07/23	Director of Primary Care, Community & Long-Term Care	**4x4=16** (Reviewed 18/10/23)	As of October 2023, 8 Dental contracts and 3 General Medical Service (GMS) contracts have been returned to the Health Board over the last 12 months. This has resulted in 25,000 dental patients being displaced. In addition, a further 8 dental practices have not signed up to the contract reform, signalling that they will return contracts once reform negotiations have concluded. 2 out of the 3 General Medical Service (GMS) contracts have become Health Board managed practices. This has resulted in additional financial pressures as the workforce is salaried, with the third practice going through the vacant practice process. It is recognised that any further managed practices would likely have a	**2x4=8**

				negative impact on the GMS budget. The number of complaints received from the public has increased due to returned contracts; and while the Health Board is currently containing the demand for urgent dental care, it is recognised that patients who don't fall into this category (but require a level of dental care) are detrimentally impacted, and that any further contracts returned will exacerbate this situation. The capacity of the Health Board in terms of staffing to absorb further contract reform will impact on the ability to effectively deliver services and will have a detrimental impact on staff welfare. With new contract implementation relating to Optometry due in January 2024, there is an expectation of a shift from hospital care to the community. However, the model is untested in terms of contractor capacity and skill set. Due to the above, the current risk score has been increased to 16.	

Note 2- De-escalated/Closed risks:
The following 2 risks have been closed/de-escalated to Directorate level on Datix since the previous meeting.

Risk Reference & Title	Date risk closed/ de-escalated	Lead Director	Current Risk Score	Reason for closure/ de-escalation

129 - Risk of the ability to deliver urgent Primary Care Out of Hours (OOH) Service due to current service model and recruitment difficulties	03/08/23	Director of Operations	**Closed**	Risk has been closed considering the new Directorate level risk drafted to supersede this risk (1700 - Risk of inability to deliver a sustainable Out of Hours service due to service fragility).
1559 - Risk of power outages across all clinical and corporate functions of the Health Board due to external influences	04/10/23	Director of Public Health	**3x4=12**	Agreed to de-escalate at Executive Risk Group (October 2023) to Directorate level.

Note 3 – Increase in risk score:
There have been increases in current risk score of the following risks since the previous meeting.

Risk Reference & Title	Date risk identified	Lead Director	Previous Risk Score	Current Risk Score	Update	Target Risk Score
1699 - Risk of loss of service capacity at Withybush General Hospital due to surveys and remedial work relating to reinforced autoclaved aerated concrete (RAAC)	13/06/23	Director of Operations	**4x5=20**	**5x5=25** (Reviewed 09/11/23)	All RAAC affected inpatient wards were vacated as of 25 August 2023, and detailed surveys completed in Wards 7,8/CCU,10, 11 & 12 with remedial work requirements identified. Works are scheduled to complete in Ward 7 by 15 December 2023, with works completed in Wards 9 and 12 and reoccupied as medical capacity from 5 October and 9 November 2023 respectively. Throughput of inpatient elective surgery, as would ordinarily be delivered from Ward 9, remains low with same day admission pathway to Day Surgery Unit (DSU). Medical patients vacated the DSU footprint on 5 October	**2x5=10**

					2023 when it returned to service with resumption of day case surgery on site. Medical patients withdrawn from the Pembrokeshire Haematology and Oncology Day Unit (PHODU) in November following reopening of Ward 12. This enabled reinstatement of full service to PHODU. Remedial works started in Ward 11 in October 2023 and scheduled to complete by the end of December 2023. Suitability of this area to be utilised as outpatient and/or therapy capacity is being scoped. Visual survey in Outpatients A has identified significant RAAC related issues (P1 planks). Detailed survey being undertaken in November 2023 with remedial works to follow and scheduled to return to service in June 2024. Alternative locations for outpatient provision are being coordinated and scoped by the Scheduled Care directorate. Schedule for detailed survey programme for ground floor areas developed with programme to complete by 31 March 2024. Remedial works are to follow detailed survey in physiotherapy area, resulting in the need to decant from February until the end of June 2024. Remedial works on Wards 8/CCU and 10	

					are scheduled to commence in January 2024, and complete in March 2024.	
1531 - Risk of being unable to safely support the Consultant on-call rota at WGH and Glangwili General Hospital (GGH) due to workforce pressures	10/11/22	Director of Operations	**2x5=10**	**4x5=20** (Reviewed 27/10/23)	The risk score has now increased, due to the uncertainty of finding and maintaining cover to ensure the rota does not collapse. The 1:3 model provided some assurance; however, the GGH and Bronglais General Hospital (BGH) Consultants are withdrawing from this model in November 2023. The risk score could be decreased once a suitable Medacs Locum is in place and recruitment of an NHS Locum has taken place (commencing in November 2023). Until then, the service will be trying to maintain a 1:4 on call rota with 3 Consultants. An informal meeting has been arranged in October 2023 with a Medacs Locum candidate. An update to reflect the current situation will be provided to the Acute Leadership Group in November 2023.	**2x5=10**
684 - Risk to the timely investment and replacing of Radiology equipment	04/01/19	Director of Operations	**3x4=12**	**4x4=16** (Reviewed 11/10/23)	The Health Board's stock of imaging equipment routinely breaks down, causing disruption to diagnostic imaging services across all sites which has a significant impact on the Health Board's ability to meet its Referral to Treatment (RTT) target. Impact to patients can include	**2x4=8**

					delays in diagnosis and treatment. Computerised Tomography (CT) and Magnetic Resonance Imaging (MRI) scanners have been replaced and has reduced the frequency of machine downtime compared to previous experience. The risk score has increased to 16, reflecting that some equipment has been installed and is operational; however further investment is required given recent breakdowns of key imaging equipment. A costed plan, along with a rolling programme for the installation of additional equipment, is in place. The next batch of equipment for replacement has been prioritised and identified, however funding has not been secured for financial year 2023/2024. As of September 2023, confirmation on funding is awaited. Gamma camera at WGH is the only scanner of its nature in the Health Board and has experienced a breakdown in August 2023 due to intermittent failures, resulting in several Healthcare Inspectorate Wales (HIW) reportable Ionising Radiation (Medical Exposure) Incidents (IR(ME)R). This item of equipment is on the current priority list of	

					items to replace as of September 2023. While a new CT scanner has been obtained and installed at GGH, the original CT scanner has had several breakdowns due to its age. The technology on this scanner is also now out of date and impacts directly on the resilience of the service at our major trauma site in the Health Board.	
1548 - Risk to the Health Board maintaining service provision due to industrial action	09/11/22	Director of Public Health	**3x3=9**	**4x3=12** (Reviewed 09/11/23)	The Royal College of Nursing (RCN) and the Society of Radiographers have accepted the enhancements to the non-pay elements of the pay offer. This concludes the Industrial Action for A4C staff. However, the British Medical Association (BMA) have declined an offer of 5% uplift (1.5% uplift for Junior Doctors including SAS Doctors) for 2023/24 to basic pay. Ballot notices have been received by employers (both Hywel Dda UHB and NHS Wales Shared Services Partnership (NWSSP)) detailing that the ballot to members has commenced and will end on 18 December 2023. This applies to Junior Doctors only. The BMA are expected to reach the 50% threshold for action. Welsh Government (WG) have been notified of the dispute directly by the BMA.	**2x3=6**

					Mitigation and contingency measures, together with command and control structures put in place during periods of previous action by Trade Unions resulted in a co-ordinated response to minimise impact as far as possible, and this has been re-established. The risk score remains the same until the ballot results have been notified to both employers. If the threshold is indeed reached, the BMA have advised that they intend to take an initial 72 hours consecutive period of industrial action in the new year. No formal notification has been received relating to the Consultants to date.	

Note 4 - No change in risk score:
There have been no changes to the 3 risk scores included in the table below since the previous meeting:

Risk Reference & Title	Date risk identified	Lead Director	Current Risk Score	Update	Target Risk Score
1032 - Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity	02/11/20	Director of Operations	**5x4=20** (Reviewed 17/10/23)	The service is experiencing significant waiting times because of increasing demand levels which are exceeding pre-pandemic levels, compounding the backlog due to Covid restrictions. Due to increasing Did Not Attend (DNA) rates, ongoing recruitment challenges and increasing demand, there is an impact on the services' ability to see the same volume of service users as they were previously able to. Some	**3x4=12**

				posts continue to be funded on fixed term basis which can make staff retention challenging along with having to train new incoming staff. As of October 2023, there are currently 2,478 clients on the waiting lists, with the longest wait noted as 215 weeks. The average wait is noted as being 74 weeks. For Autism Spectrum Disorder (ASD), a meeting took place with the Delivery Unit (DU) to establish trajectories, along with the commissioned service which were agreed in March 2023. The DU were unable to provide trajectories, therefore the Health Board has agreed to a 1% trajectory. For psychological services a trajectory is now in place for 1% per month.	
797 - Risk to the ability to deliver ultrasound services due to workforce pressures	07/11/19	Director of Operations	**5x4=20** (Reviewed 10/11/23)	Despite best efforts, the service remains fragile. Vacancies remain unfilled, with the inability to recruit, despite repeated recruitment attempts. Long term vacancies exist in BGH, Prince Philip Hospital (PPH) and WGH. There are several expected retirements and planned maternity absences in the near future across all sites. There will also be the inability to secure agency staff due to current financial climate of the Health Board. While a Modality Lead at WGH has been appointed and recently commenced, the ability to undertake	**3x4=12**

				governance and audit requirements still needs to be embedded. However, it is noted that a Radiology Ultrasound Governance group was set up in June 2023. More sonographers are due to be trained from January 2024, however training takes two years to complete. While 3 of the 4 vacancies advertised in July 2023 have been successfully appointed to, this has not resulted in additional capacity to the service as roles have been given to previous locum staff.	
1027 - Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	19/11/20	Director of Operations	**4x5=20** (Reviewed 31/10/23)	Levels of urgent and emergency pathway capacity pressures continue at significantly escalated levels. This is driven by post pandemic demand and the broader impacts of COVID-19. Workforce deficits, handover delays, 4 and 12 hour performance, bed occupancy rates and significant pressures on wider community and social care capacity are all demonstrating significantly worrying trends. The indirect legacy of the pandemic has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. The situation remains at high levels of risk escalation across our acute sites daily. Notwithstanding these challenges, positive progress has been achieved since January 2023 in reducing peak levels of pressure with	**3x4=12**

				notable improvements achieved in key Urgent and Emergency Care (UEC) pathway metrics relating to ambulance handover and Emergency Department (ED) waiting times. Progress remains consistent with small incremental improvements, and as of May 2023 the risk score was reduced to 20 based on likelihood. While performance metrics are demonstrating incremental improvements, as of October 2023 the current risk score to remain at 20.		

Argymhelliad / Recommendation

The Committee is requested 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.
- Challenge where assurances are inadequate.

This in turn will enable the Committee to provide the necessary assurance to the Board, through its Committee Update Report, that the UHB is managing these risks effectively.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.2 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. 3.3 Recommend acceptance of risks that cannot be brought within the UHBs risk appetite/tolerance to the Board through the Committee Update Report. 3.4 Receive assurance through Sub-Committee Update Reports that risks relating to their areas are being effectively managed across the whole of the UHB's activities (including for hosted services and through partnerships and Joint Committees as appropriate).
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Contained within the body of the report
Parthau Ansawdd:	7. All apply

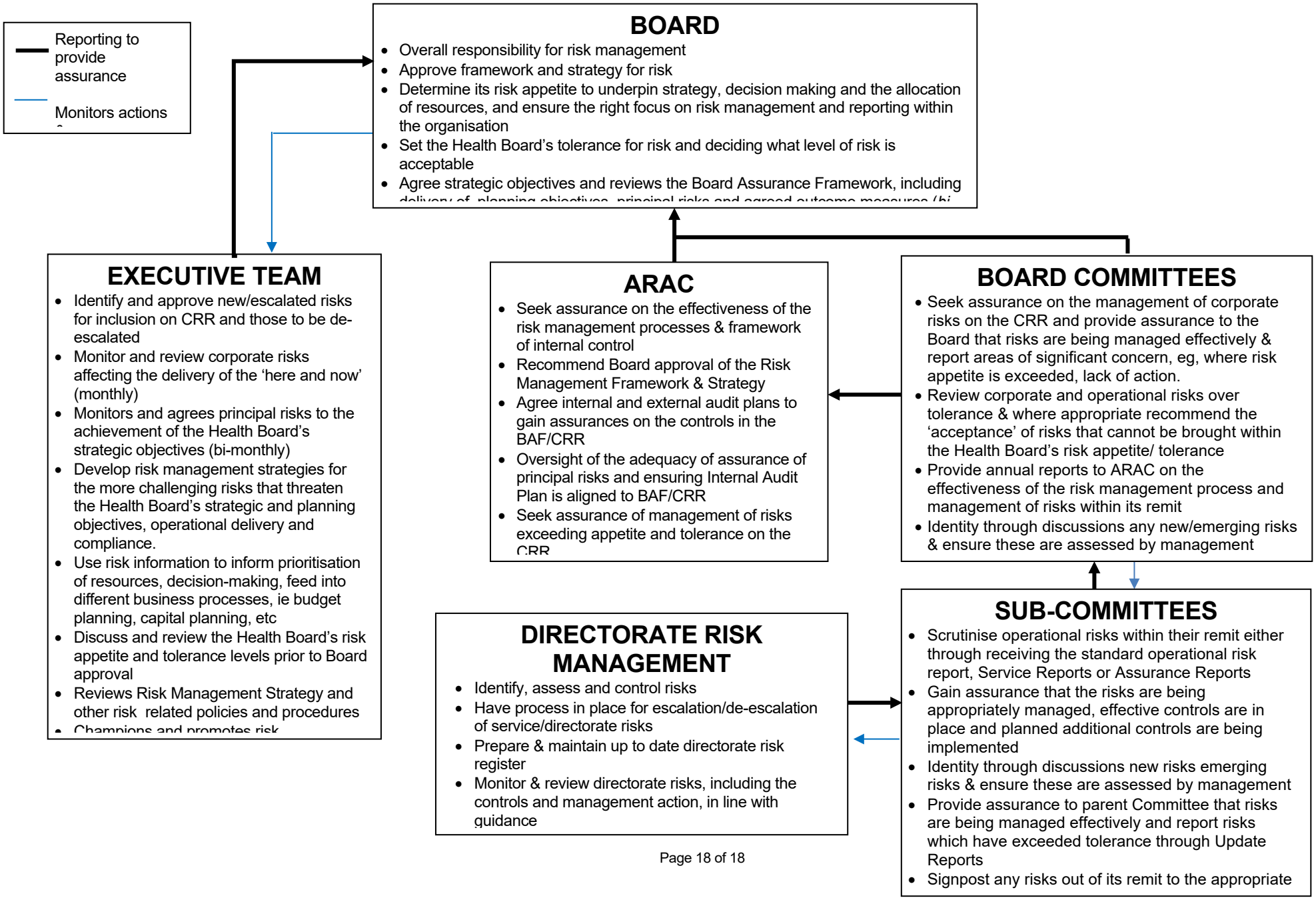
Domains of Quality Quality and Engagement Act (sharepoint.com)	Choose an item. Choose an item. Choose an item.
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply Choose an item. Choose an item. Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable Choose an item. Choose an item. Choose an item.
Amcanion Cynllunio Planning Objectives	Not Applicable Choose an item. Choose an item. Choose an item.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Underpinning risk on the Datix Risk Module from across the UHB'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
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	N/A

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:**	Has EqIA screening been undertaken? No Has a full EqIA been undertaken? No

Appendix 1 – Committee Reporting Structure



Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Nov-23	Trend	Target Risk Score	Risk on page no...
1699	Risk of loss of service capacity at WGH due to surveys and remedial work relating to RAAC	Carruthers, Andrew	Service/Business interruption/disruption	6	4×5=20	5×5=25	↑	2×5=10	3
797	Risk to the ability to deliver ultrasound services due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	8	5×4=20	5×4=20	→	3×4=12	8
1027	Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×5=20	4×5=20	→	3×4=12	12
1032	Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	5×4=20	→	3×4=12	17
1531	Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	6	2×5=10	4×5=20	↑	2×5=10	24
1664	Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Carruthers, Andrew	Safety - Patient, Staff or Public	6	New Risk	4×5=20	New Risk	2×5=10	27
684	Risk to the timely investment and replacement of Radiology equipment	Carruthers, Andrew	Service/Business interruption/disruption	6	3×4=12	4×4=16	↑	2×4=8	33
1708	Risk of increasing fragility in primary care contractor services due to recruitment challenges	Paterson, Jill	Service/Business interruption/disruption	6	New Risk	4×4=16	New Risk	2×4=8	38
1548	Risk to the Health Board maintaining service provision due to industrial action	Gjini, Ardiana	Safety - Patient, Staff or Public	6	3×3=9	4×3=12	↑	2×3=6	42

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

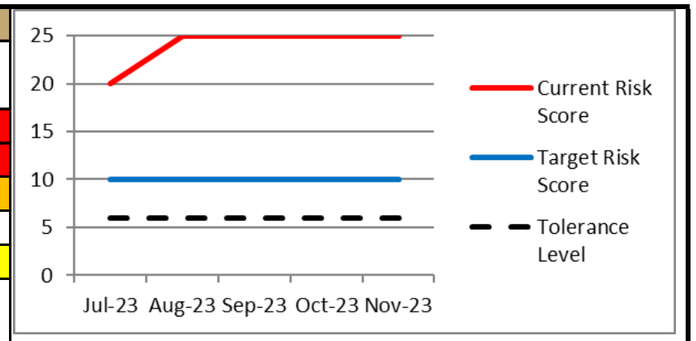
Appendix 3

Date Risk Identified:	Jun-23	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Nov-23
Strategic Objective:		**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Dec-23

Risk ID:	**1699**	**Principal Risk Description:**	There is a risk that there could be a significant loss of capacity to deliver elective, urgent and emergency and outpatient services at Withybush Hospital (WGH), and the delivery of the Health Board's Annual Plan 2023/24. This is caused by by the requirement to undertake surveys and take immediate disruptive remedial works, where necessary, to address findings of reinforced autoclaved aerated concrete (RAAC) surveys at WGH, which may result in a number of wards being concurrently closed whilst surveys and remedial works are undertaken. This could lead to an impact/affect on the ability to safely manage demand across elective, urgent and emergency inpatient and outpatient services, including patients accessing specialist areas for care (including coronary care, complex oncology, gastroenterology, respiratory and stroke), disruption to pharmacy services, and poorer patient outcomes from overcrowding in the Emergency Department resulting in delays in accessing care and treatment. This will affect the Health Board's ability to achieve ministerial priorities as set out in the Annual Plan 2023/24 (eg, improvements to ambulance response times and emergency department waiting times). There may also be increased scrutiny from key stakeholders, including Welsh Government and other regulators which may lead to the loss of public confidence, and increased pressures on current workforce.

Does this risk link to any Directorate (operational) risks?	1382, 1385, 1657, 1027, 1711, 1722

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	5×5=25
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	↑



Appendix 3

Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
All RAAC affected inpatient wards vacated as of August 25th 2023. Detailed surveys complete in Wards 7,8/CCU,10, 11 & 12 with remedial work requirements identified. Works scheduled to complete in Ward 7 by December 15th 2023. Works completed in Wards 9 & 12 and reoccupied as medical capacity from 5th October & 9th November 2023. Throughput of inpatient elective surgery, as would ordinarily be delivered from Ward 9, remains low with same day admission pathway to Day Surgery Unit (DSU). Medical patients vacated the DSU footprint on 5th October 2023 when it returned to service with resumption of day case surgery on site. Medical patients withdrawn from the Pembrokeshire Haematology & Oncology Day Unit (PHODU) in November following reopening of Ward 12. This enabled reinstatement of full service to PHODU. Remedial works started in Ward 11 in Oct 2023 and complete by end of December 2023. Suitability of this area to be utilised as outpatient and/or therapy capacity is being scoped. Visual survey in Outpatients A has identified significant RAAC related issues (P1 planks). Detailed survey due to complete on 10th November with remedial works to follow, scheduled to return to service at end of June 2024. Alternative locations for outpatient provision being coordinated and scoped by scheduled care directorate. Schedule for detailed survey programme for ground floor areas developed with programme to complete by March 31st 2024. Remedial works to follow detailed survey in physio/therapy area, resulting in need to decant from February - end of June 2024. Remedial works on Wards 8/CCU,10 are scheduled to commence in January 2024, and complete in March 2024.	Surveys being undertaken will result in appropriate project plans being put in place, which once completed will reduce the likelihood of service disruption. There are a high number of "amber" planks which will require yearly monitoring & inspection over the coming years, with the possibility that they may also deteriorate and require additional remedial work in the future.

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**
Use of Cleddau Ward (East and West) in South Pembs Hospital, to reprovide 28 non acute inpatient beds to those meeting a pre-determined criteria Implementation of different model of care in Cleddau Ward to facilitate improved patient flow	Clarity on funding streams required to progress remedial works. Health Board Discretionary Capital allocation used to commence works in Wards 9 & 12. Further funding remains unapproved. To continue with this programme at pace is significantly	To explore funding options with Welsh Government to support remedial work	Davies, Lee	Completed	Funding has been approved by Welsh Government to deliver a programme of survey and remedial works to address high risk RAAC in 2023/24 and 2024/25 financial years.

Emergency pathways, reviews and developments in place to minimise admissions and length of stay (LOS) in hospital Optimising available inpatient capacity, where possible. Reduced elective surgery activity on site pending completion of remedial works Maximising use of potential bed capacity in areas across WGH not affected by RAAC. Conveyance avoidance measures in place including clinical triaging of Health Care Professional referrals to secondary care Comprehensive plan in place to undertake planned surveys - contractor on site. Fast Track Visual Surveys and detailed surveys complete. Ground floor detailed surveys to commence mid October 2023. Commenced programme of works, Pot Wash area & Ward 9 complete. Wards 7 and 12 commenced (planned completion mid December & early November respectively). Ward 11 repair works programme due to complete early Jan 2024 with potential to accommodate outpatient activity being scoped. Wards 8 & 10 due to complete works end March 2024. Utilising Acrowprop and/or hybrid measures to mitigate impact and reduce risk until repair works are undertaken Internal and External Communications undertaken and planned approach going forward WGH RAAC Implementation Group, consisting of key estates and service management Business Continuity Incident declared on 15Aug23, and a Command Control Structure (Gold Silver/Bronze) established to coordinate and manage Health Board response. Liaising with other hospital sites in England to understand how they've managed the situation	beyond that which can be supported by our Discretionary Programme Clarity on scope and associated timelines of the required remedial works Ability to provide catering on site during and following survey whilst awaiting remedial works Ability to manage impacts from loss of medical bed capacity is more challenging as numbers of bed losses increase and winter approaches Operational position on other sites does not easily support transfer of clinical pathways Ability to transport emergency and non-emergency patients to alternative sites	To minimise scope and level of disruption as far as reasonably practicable by combining Phase 2 Fire Works with RAACs remedial works, where possible	Chiffi, Simon	~~31/07/2023~~ 30/09/2023 31/03/2024	The scope document to reduce extent of Fire Investment at WGH was submitted in September 2023. In advance of a decision from Fire Service on this, the decision was made to proceed with the fire requirements as proposed in the submission. This was on the basis that as long as approval was received we would avoid further disruption to the 6 wards impacted by RAAC. As we have proceeded with the RAAC work, the fire elements have been incorporated, and envisaged completion of these works by March 2024. Verbal approval received from the MWWFRS on 8th November 2023 that our scope document has been approved, and a request for formal notification has been made, and expected to be received by December 2023.
		Develop a programme of works at WGH to address survey outcomes	Williams, Paul	Completed	Detailed surveys complete for all the wards and ongoing for the ground floor areas, with planned completion by end of March 2024. Current timescales include the completion of works for all Wards in financial year 2023/24 and the completion of all ground floor areas by end of August 2024. Construction works completed for Wards 9 and 12. Outpatients Department A is currently being surveyed to support remedial works, scheduled to start in February 2024.
		Liaise with affected services and departments to communicate the expected impact of service disruption on their areas	Cole-Williams, Janice	~~31/07/2023~~ 30/09/2023 30/11/2023 31/12/2023	Site management liaising with services to confirm requirements for detailed survey and expected disruption in relation to corridors, office & clinical space, as well as supporting service relocation for survey and works as required. This will continue whilst surveys and remedial works are undertaken.

	Reviewing service delivery response and developing contingency plans in the event of losing significant clinical capacity	Carruthers, Andrew	~~30/09/2023~~ 30/11/2023 31/12/2023	Work is being undertaken to maximise use of bed capacity in areas across WGH not affected by RAAC, with additional bed capacity being scoped and utilised in South Pembrokeshire Hospital. Increased bed capacity in Puffin Ward by further 5 beds. Alternative means of elective surgery provision being explored across Health Board and wider region. Outpatient services relocated or switched to virtual if at all possible to release capacity during survey and remedial works. Re-phasing plan to reintroduce inpatient capacity onto the WGH site whilst closing down additional capacity opened to mitigate bed loss. 13 beds in Cleddau ward to close in Dec 2023 when Ward 7 reopens. This, together with opening an additional 8 beds in Ward 12, will increase acute medical bed capacity. Pembs system bed modelling project commenced to ensure required capacity to meet demand reopens in the right place, whilst the impact of programmes in intermediate care (eg clinical streaming hub, frailty pathway, SDEC, virtual ward) are understood and considered when reopening inpatient capacity.
	Scoping alternative catering arrangements for WGH	Elliott, Rob	Completed	Cook freeze solution established up to implementation of temporary kitchens scheduled to be operational from early December 2023. Survey and remedial works to be arranged and main kitchen returned to operation use by August 2024.

Appendix 3

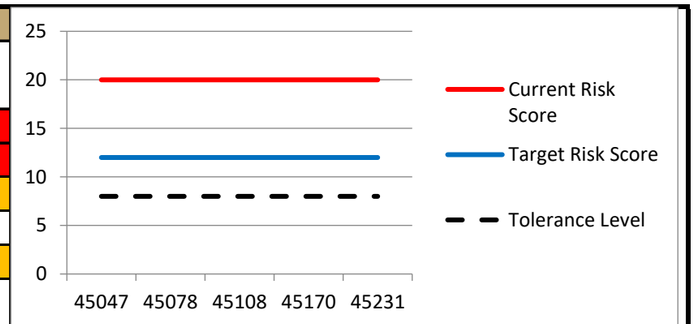
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES			
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**			**Identified Gaps in Assurance:**	**How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
Project plans in place dependant on outcomes of surveys, and monitored via the WGH RAAC Implementation Group	Fortnightly WGH RAAC Implementation Group meetings	1st			RAAC paper to SDODC (Apr 23) RAAC paper to HSC (Jul 2023) RAAC included in Director of Operations Report to Board (Jul23)	Unaware of the extent and impact of the risk until all surveys have been completed. All inpatient areas now surveyed as at September 2023, with P1 planks identified, and works schedule confirmed. Ground floor detailed survey planned for Oct 2023-Mar 2024. Amber planks remain in situ and require ongoing monitoring with risk of deterioration unknown.	Urgent programme of assessment to be undertaken to assess remaining areas	Elliott, Rob	30/09/2023	Risk assessments currently being undertaken by the Estates and Facilities Directorate on remaining areas, the outcomes of which will assist in the decision on next steps regarding ward closures. Fast track visual inspection commenced to rapidly identify and mitigate risks over the c. 10-week programme
	Command and Control Structure established to coordinate Health Board response	2nd								
	RAAC survey findings by external contractor	3rd								

Appendix 3

Date Risk Identified:	Nov-19		**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Nov-23
Strategic Objective:			**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Dec-23

Risk ID:	**797**	**Principal Risk Description:**	There is a risk of being unable to provide a full range of ultrasound services including antenatal across the Health Board. This is caused by the retirement and resignation of current sonography staff, low availability of sonographers UK wide, and the inability to recruit to due national shortages of qualified staff, and the inability release existing workforce to train and develop to meet current service demands. This could lead to an impact/affect on delays in diagnosis which could result in detrimental outcomes for patients, inability to meet diagnostic targets and cancer pathway targets, and an inability to hold clinics to meet demand in ante natal screening services within required timescales. In addition, there is an impact on staff health and wellbeing in terms of the volume of patients examined within a shift/overtime, which could lead to increased incidents of repetitive strain injuries (RSI), along with increased incidents of staff stress and burnout. This could ultimately lead to increased errors when performing the dynamic diagnostic test.
Does this risk link to any Directorate (operational) risks?		1557, 1349, 1658	

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):	5×4=20
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:
Despite best efforts, the service remains fragile. Vacancies remain unfilled, with the inability to recruit despite repeated recruitment attempts. Long term vacancies exist in Bronglais, Prince Philip and Withybush. There are a number of expected retirements and planned maternity absences in the near future across all sites. There will also be the inability to secure agency staff due to current financial climate of the Health Board. While a modality lead at Withybush has been appointed and recently commenced, the ability to undertake governance and audit requirements still needs to be embedded, however it is noted that an Radiology Ultrasound Governance group has been set up in June 2023. More sonographers are due to be trained from January 2024, however training takes two years to complete. While 3 of the 4vacancies as advertised in July 2023 have been successfully appointed to, this has not resulted in additional capacity to the service as roles have been given to previous locum staff.

Rationale for TARGET Risk Score:
The actions below will not in themselves reduce this risk significantly. Support is required to undertake the demand and capacity and the current establishment reviews. It is likely that these reviews will lead to a need for further investment and additional funding to establish a sustainable service model to include a robust perpetual training programme, that will enable the Health Board to met expected diagnostic waiting times targets.

Appendix 3

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**
Process in place for the movement of staff across the Health Board to maintain capacity. Ultrasound Control Group in place	The PPH modality lead has left however will be a secondment filled for a 6 month period. Inability to release existing staff to train and develop to undertake sonography and growth scans. Inability to recruit and retain staff. Ultrasound Control Group has not met since July 2023 due to operational pressures. While process in place regarding the movement in staff, due to current staffing levels and pressures this is not being implemented	Develop a plan to help alleviate pressures through increasing the number of growth scan checks undertaken by midwives.	Lingwood, Gill	~~31/12/2022~~ 31/10/2023 31/01/2023	Discussions have taken place with Head of Maternity Services. Protocols and training being developed. Implementation date to be agreed. Meeting scheduled for 20th June 2023 with CVUHB in order to assist with the development of a training plan. Midwifery services approached Powys for assistance with training midwife sonographers and appointed 2 midwives to join the ultrasound Course for January intake 2024. However, Powys are unable to support training in the same original capacity and the certainty around midwife training in January is currently unknown.
		Train members of staff to become sonographers, the number of which dependant on capacity to take training.	Roberts-Davies, Gail	~~31/03/2020~~ ~~31/12/2022~~ ~~01/02/2023~~ ~~30/09/2024~~ 31/01/2026	As at June 2023, it is hoped that 4 members of staff can be trained - however this is dependant on the desire of current to undertake the training, and the ability to recruit to training positions. Training positions take two years to complete, with a view to these commencing in January 2024. Clinical Educator roles have been developed, with job descriptions being presented to panel in June 2023, after which the Directorate will be able to advertise these vacancies, however recruitment was unsuccesful.

Work with the workforce planning team to build a sustainable workforce plan for ultrasound services.	Roberts-Davies, Gail	~~31/10/2023~~ 31/03/2024	Fortnightly workforce planning meetings in place with colleagues from Radiology and Workforce in attendance. Plan for a sustainable service has yet to be developed as at September 2023.
Seek support to undertake a demand and capacity (D&C) review and detailed establishment review of the radiology service.	Jones, Keith	~~30/06/2022~~ ~~30/11/2022~~ ~~31/03/2023~~ 30/08/2023 31/01/2024	Initial contact made with workforce planning team re: establishment review work, and this work is also being supported by the Value Based Health Care team as of November 2022. This has been discussed in the Radiology Use of Resources Meeting and further discussions are taking place in regard to establishing a Radiology Planning and Delivery Group to bring together all pieces of work with the necessary expertise. It is noted that this group has yet to be established as of April 2023, however a focussed Ultrasound Control Group has been set up, recognising the imminent loss of service. Radiology dashboard is now in place and functional. As of November 2023 there have been some signifcant staff changes on various sites with the loss and gain of sonographer hours. D&C needs further review.

	Explore opportunities of recruitment/training of physiotherapists, midwives and other Allied Health Professionals to undertake ultrasound examinations	Roberts-Davies, Gail	Completed	Opportunities are discussed via the Ultrasound Control group which commenced 21st April 2023. These options have been offered to relevant staff, who have the opportunity to apply. Once clinical educators are in post, any internal vacancies which remain will be advertised externally as training posts for Allied Health professionals.

Appendix 3

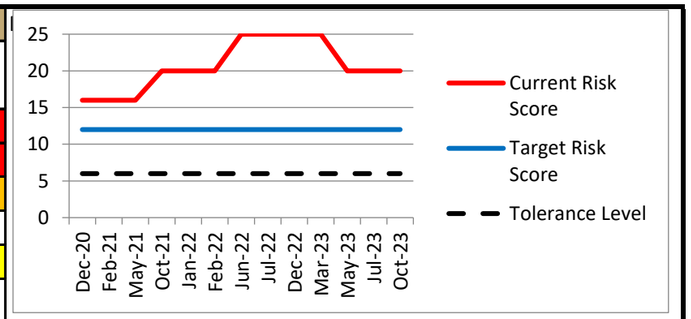
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level	Control RAG Rating (what the assurance is telling you about your	Latest Papers (Committee & date)	Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Non-Obs ultrasound - currently >over 40 weeks Radiology Dashboard IPAR Reports WG Cancer PTL, reported monthly	Management review of sonography and SCP diagnostic waiting times	1st			Sonography Report to Acute Bronze and Operation Planning and Delivery Programme meeting					
	Monthly review of USC performance undertaken monthly (24% of USC carried out in 7 days, 41% carried out in 14 days at March 2023), included in the IPAR & reported to WG	1st								
	Performance monitored at Directorate Improving Together Sessions	2nd								
	Performance monitored via IPAR, overseen SDODC & Board	2nd								

Appendix 3

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Oct-23
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Nov-23

Risk ID:	**1027**	**Principal Risk Description:**	There is a risk to the consistent delivery of timely and high quality urgent and emergency care. This is caused by significant fragility across the urgent and emergency care (UEC) system (acute, primary care (including out of hours), community and social care services), related to workforce compromise and increasing levels of demand and acuity. 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 and overcrowding at Emergency Departments 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?		1649, 1406, 1548, 1210, 750, 205, 86,	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
Levels of urgent and emergency pathway capacity pressures continue at significantly escalated levels. This is driven by post pandemic demand and the broader impacts of COVID-19. Workforce deficits, handover delays, 4- and 12-hour performance, bed occupancy rates and significant pressures on wider community and social care capacity are all demonstrating significantly worrying trends. The indirect legacy of the pandemic has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. The situation remains at high levels of risk escalation across our acute sites on a daily basis. Notwithstanding these challenges, positive progress has been achieved since January 2023 in reducing peak levels of pressure with notable improvements achieved in key urgent and emergency care (UEC) pathway metrics relating to ambulance handover and emergency departments (ED) waiting times. Progress remains consistent with small incremental improvements, and as at May 2023 the risk score was reduced to 20 based on likelihood. While performance metrics are demonstrating incremental improvements, as at October 2023 the current risk score to remain at 20.	There is a significant challenge across the Urgent and Emergency Care system. The combined impact of the multi-faceted pressures which underpin this risk have led to an incremental increase in the overall level of pressure as reflected in deteriorating delays for ambulance handover, access to urgent and emergency care and delayed discharges. The extent to which these combined pressures impact upon the timeliness and quality of care provided is related to the overall availability of staffing resources on a daily / weekly basis, which in turn is influenced by increasing levels of staff sickness/absence. In light of the positive progress achieved in since January 2023 in reducing peak levels of pressure with notable improvements achieved in key UEC pathway metrics relating to ambulance handover and ED waiting times, this risk and target risk score will be reviewed and revised for 2023/24.

Appendix 3

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 which include efficient handover from WAST into ED. # 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. # 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 and specifically reviews COVID-related absence and forward forecast. # Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites. # Regular advice 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. # 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. # Domiciliary Care Risk and Escalation Policy approved by Integrated Executive Group and implemented across Health Board # 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, urgent and emergency care plan agreed. # Establishment of a Discharge to Assess (D2A) Group which reports to	# Fragility of Care Home Sector exacerbated by COVID related issues such as financial viability, staffing deficits, recruitment and retention of workforce. # Significant paucity of domiciliary care/social care availability due to recruitment and retention of staff # Nurse staffing availability to ensure safe levels of care as a consequence vacancies. # Post-COVID-19 fatigue is exacerbating workforce capacity and availability of bank and agency staff who would be available. # COVID-19 incidence continues to further exacerbated workforce capacity and availability of bank and agency staff who would be available. # Inability to offload ambulances to release them back for use within community. # Increased pressures at ED as a result of WAST ambulance response policy resulting in very poorly patients self-presenting. # Better understanding of ED presentations to ensure development of alternative pathways in primary care / community to prevent ED attendance # Effective and timely communication to the public at times of pressure but also of safe alternatives to hospital admission / ED presentation that will contribute to changing public mind set / expectation and culture in terms of use of NHS resource and 'Home First' # Education and training for best practice in frailty management	Refer CRR 1649 detailing actions to address insufficient workforce to support delivery of essential services.	Gostling, Lisa	31/03/2024	Ref CRR 1649 for detailed progress.
		To undertake a quality improvement project to map flow across GGH unscheduled system supported by Improvement Wales.	Perry, Sarah	~~31/12/2022~~ 31/12/2023	Work is ongoing, and being rolled out to PPH and GGH
		Incorporate and deliver actions that will address control gaps into the Health Board's UEC Plan.	Carruthers, Andrew	31/03/2025	Launch of the UEC Improvement Programme on 16/06/22 to galvanise a collective approach to improvement, and ongoing as at May 2023. The Annual Recovery Plan for 2023/24 outlines the UEC improvement actions being progressed during the current financial year in support of this longer-term objective. These are overseen and monitored by the TUEC steering group, chaired by the Director of Operations.
		To implement the Standard for Discharge to Assess in accordance with the WG 6 Goals Guidance	Matthews, Rhian	Completed	This work has now been superseded by the policy goal work, with Policy Goal 5 rolled out across both GGH and PPH, led by the QIST team. Weekly progress reports are sent to the General Manager, Heads of Nursing and Senior Nurse Managers.

the Unscheduled Care group. # 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 # To optimise step down bed capacity in the community across care homes and community hospitals # SRO in place to lead agreed Urgent and Emergency Care (UEC) programme # Supernumery HCSWs aligned to the acute response teams to support failing community care capacity # Support for complex discharge caseload management tool (SharePoint) appointed # Reminders issued to management on importance of robust management of staff sickness and the use of COVID-19 Risk Assessment to help manage staff absences. # SDEC models continuously reviewed and refined to maximise impact on admission avoidance. # Staff are encouraged to participate in the UHB's ongoing COVID-19 vaccination programme. # Alternative models of medical oversight i.e service level agreement with local GPs and HB salaried community GPs. # Service provision in the community for people pending ambulance conveyance, and where conveyance is not possible to manage ambulance handover delays. # Increased bedding capacity in community hospitals. # UEC live performance dashboard in place. # Local streaming hub. # Direct referral into SDEC in WGH, GGH and PPH. # Operational joint meeting with WAST to identify and taking forward key action to help address conveyance. # Clinical Streaming Hub includes APP Navigator working with Physicians to triage and stream patients pending conveyance to more appropriate pathway in the community (In Hours).	mandated to effect culture of 'unsafe to admit' for our very / severely frail # Supporting staff to be able to better manage family dispute relating to expectation eg home of choice, transfer pathways to short term placement in care home pending home care availability # Development of a 'tool' that supports staff to assess risk across the whole system to support decision making when discharge appears to be 'risky' to the individual patient. This includes decision making for 'further rehabilitation required in the acute environment' (why not at home?), further blood analysis to confirm medically fit to discharge, home care not available but family happy to take in the interim. # For all patients with LOS > 21 days the need for escalation and 'senior think tank' # If there is a paucity of home care to the extent that we are unable to provide > 28 hours per week (calls four times per day) - why are we advocating this level of commissioning? # Clarity regarding roles and responsibilities for discharge planning and coordination # The availability of live data at Cluster, County and Site level with sufficient analytical support # the ability to risk stratify for people at moderate to high risk of admission in the community to implement proactive anticipatory care plans to support avoidance of exacerbation / decompensation and hence increased risk of hospital admission # Optimising our bedded facilities in	To review findings of local Peer Review and data analysis to inform SDEC model 2023/24	Matthews, Rhian	Completed	A review of the findings has been completed, with proposals derived from the Peer Review agreed. Further enhancements to the site specific SDEC models will be overseen by the Managing Complexity and Conversion Workgroup, next meeting scheduled for 11th October 2023. The outcomes of this meeting will inform future actions for this risk.
		To review findings of GP Out Of Hours (OOH) Peer Review, and implement actions as part of planning objective 3A	Matthews, Rhian	Completed	Review has been undertaken, and work is ongoing as part of the TUEC programme to look at closer working links between in-hour Intermediate Care GPs and GP OOHs services, and GP OOH service having access to the community and Local Authority pathways

	the community i.e we should aim for 'step up' from community and from 'front door' hospitals (within 72 hours) rather than as a 'step down' from acute hospitals after long length of stay. LOS should be no more than 10 days # Bespoke recruitment targeted at critical posts that will deliver				

improvements in UEC eg ANPs, APPs, PAs etc. and accept risk to permanently fund such posts i.e should not be temporarily funded. # Frailty screening by staff in ED and reporting into WPAS to support risk stratification of patient cohorts who should spend no more than 10 days in hospital. Majority should be turned around in 12 hours and < 72 hours. # Frailty screening and reporting into WPAS of inpatients who either have formal care in place on admission or whose level of frailty on admission suggests a need for care and support on discharge. This will support risk stratification to support discharge planning and coordination. # Consideration of workforce development for existing staff but also bespoke opportunities for non clinical roles that releases clinical time for 'clinicians to only do what they can do' # Reduce service duplication across sites # Inconsistent clinical provision for the Out of Hours (OOH) Service # Development of 24/7 urgent primary care service that integrates urgent primary care service in the day and GPOOH and provides timely information, advice and assistance to patients and clinicians to provide safe alternatives to hospital admissions.	To develop a plan with Local Authority partners that sets out a model for integrated community health and care provision for older adults and adults living with frailty	Paterson, Jill	30/11/2023	Work is underway across the three counties.

Appendix 3

Appendix 3

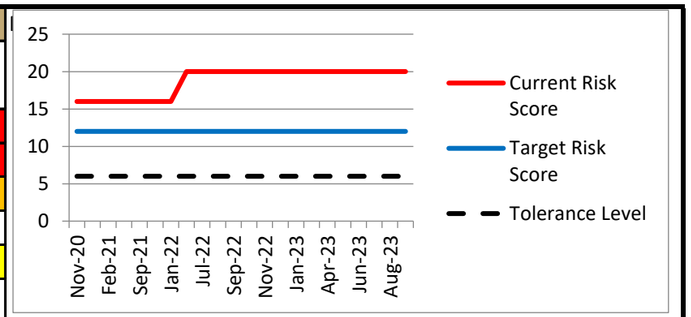
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance indicators. 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				None identified.				
	Daily performance data overseen by service management	1st								
	Delivery Plans overseen by Unscheduled Care Improvement Programme	2nd								
	Bi-annual reports to SDOPC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	IPAR Performance Report to SDOPC & Board	2nd								
	WAST IA Report Handover of Care	3rd								
	11 x Delivery Unit Reviews into Unscheduled Care	3rd								
	Delivery Unit Report on Complex Discharge	3rd								

Appendix 3

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Oct-23
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Nov-23

Risk ID:	**1032**	**Principal Risk Description:**	There is a risk to the delivery of timely diagnosis to those on the ASD waiting lists, and the commencement of interventions for Psychological Therapies (Integrated Psychology Therapies - Adult and Learning Disability) within required timescales. This is caused by an increase in referrals and increasing DNA rates, as well as recruitment challenges, and lack of appropriate estates. This could lead to an impact/affect on those currently awaiting diagnosis and intervention, resulting in delays in care and appropriate treatments in a timely manner which may lead to poorer patient outcomes, and delayed adjustments to educational needs. There will also be an impact on the ability of the Health Board to meet Welsh Government targets (diagnosis of ASD within 26 weeks, and commencement of interventions for Psychological Therapies within 26 weeks) which could lead to increased scrutiny from regulators, and escalation from Welsh Government. This in turn could result in adverse publicity and a reduction in stakeholder confidence.
Does this risk link to any Directorate (operational) risks?			138, 1249, 1286, 1287, 1392, 1455,

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):	5×4=20
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
The service is experiencing significant waiting times as a result of increasing demand levels which are exceeding pre-pandemic levels, compounding the backlog due to Covid restrictions. Due to increasing Did Not Attend (DNA) rates, ongoing recruitment challenges and increasing demand there is an impact on the services' ability to see the same volume of service users as they were previously able to. Some posts continue to be funded on fixed term basis which can make staff retention challenging along with having to train new incoming staff. As at October 2023, there are currently 2,478 clients on the waiting lists, with the longest wait noted as 215 weeks. The average wait is noted as being 74 weeks. For Autism Spectrum Disorder (ASD), a meeting took place with the Delivery Unit to establish trajectories, along with the commissioned service which since have been agreed in March 2023. The DU were unable to provide trajectories, therefore Health Board has agreed to a 1% trajectory. For psychological services a trajectory is now in place for 1% per month.

Rationale for TARGET Risk Score:
The Directorate is prioritising implementation of WPAS in key areas within MHLD and this will enable improved reporting and waiting list management and enable forward trajectories of improvement in waiting times to be determined. The target risk score will be dependent on securing recurring funding for the IAS as well as having access to appropriate clinical venues and other agencies being able to undertaken their associated assessments. While trajectory plans are in place as of March 2023, there is recognition that the Health Board will not achieve WG targets.

Appendix 3

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**
Use of IT/virtual platforms such as AttendAnywhere when appropriate. Clinical prioritisation regarding assessment and treatment of service users by engaging in a dynamic process of reviewing waiting lists in line with any other referrals that may be received in respect of that service user. Additional funding received in 2022/23 for ND service Services are in contact with individuals to provide information regarding mainstream/Tier 0 support, wellbeing at home and guidance should their situation deteriorate. Process in place to ensure individuals on waiting lists are being contacted periodically through the wait for assessment/treatment to monitor any alteration in presentation. Consultation service in place within Childrens Neurodevelopmental Service and access to integrated ASD hubs Quarterly meetings with Women and Children's Service to strengthen interdepartmental working. ND Service Delivery Manager appointed and in place. Continual review of vacancies via MHLD QSE meetings resulting in the consideration of alternative staffing models when recruitment drives do not materialise. Workforce Management Group has been established which meets monthly. Trajectories have been identified for IPTS and there are systems in place to monitor waiting lists at service level, through IPAR and Directorate and service level review meetings. Monthly meetings with Estates to look at accessing/leasing/enhancing the current MH estates with a view to increase MH estate footprint. Work underway across all services who have waiting times, be they intervention or assessment. Use of HB Third Party Contractor has begun and initial letters sent to those waiting appointments with the Integrated Autism Service. Public facing webpages with QR codes are also being developed to give further guidance and support whilst individuals are waiting. Keeping in touch template letters developed within further areas, and monitored by individual service leads.	Estates issues remain a challenge as identified in the risk narrative. Information not currently included on Health Board website and QR codes due to IT difficulties Additional funding received in 2022/23 for ND service on a fixed term basis until 2025 Current resource does not provide sufficient capacity to meet demand	Keeping in touch processes to be in place (Adult Inpatient and Learning Disabilities Services).	Bassett-Gravelle, Ms Lisa	Completed	Psychology In May 2023, 52 (40.00%) patients out of 130 were waiting less than 26 weeks to start psychological therapy in the Learning Disabilities Psychology Service. 78 (60%) were waiting more than 26 weeks. This is a month on month improvement since January 2023 and the position is likely to further improve due to Psychologists returning from maternity leave and recruitment. All new referrals are screened by the Community Teams and priority given where possible. Waiting lists review has been undertaken and keeping in touch letters in easy read have been sent out to all on the waiting list. We have recruited 8b psychologist who commences in August 2023. OT Urgent referrals taking priority. • Continue to prioritise referrals and support workforce modelling as part of service improvement work underway. • Additional up-skilling B4 techs • Reviewing universal offers of support/workshops for families and carers particularly around sensory processing referrals. • Reviewing use of caseload weighting tools and enhanced professional lead oversight of caseloads • Limited clinical support from AMH B7 in Pembs CTLD. • Additional 1.0WTE B6 OT post to cover Carmarthenshire, and 1.0WTE OT B6 post within WEIT being proposed as part of SIP. Physio

Monitored by individual service leads. Service Leads secured opportunities for outsourcing for CAMHS ASD and Psychological Therapies. Commissioned external provider for ASD services across all ages, similar contract out to tender for Psychological Therapies. 'Grow your own' scheme is coming into place with funding provided in academic year 23/24 for 3 places on the Clinical Psychologist programme (3 year programme). Quarterly meetings with the NHS Executive, Welsh Government and Service Leads at the Health Board SMS functionality in place for ND and IPTS to improve attendance and decrease instances of DNA					Physio LD Service Manager EOC will attend peer meetings in the absence of a professional lead. EOC has advised the Physiotherapist that she will be validating and monitoring the waiting list reporting to the Information Dept on a monthly basis until they have a Prof Lead in place. Services developing a professional lead physio for LD JD. All LD Therapies Service Manager EOC has advised the to adopt Psychology's approach of formally writing to each individual on the WL over 6/12 as part of the regular Waiting list review cycles.
			Identify alternative venues/space to hold clinics(CAMHS & Psychological therapies).	Lodwick, Angela	~~31/03/2023~~ 30/12/2023	Challenges continue in access to Estates to undertake assessments across the three counties. Remains ongoing working with Estates and submitting capital bids to WG for monies to fund works within allocated buildings to make them fit for purpose. SBAR being developed to repurpose the use of Tudor House. RAAC issue is extenuating the estates position with some areas within Pembrokeshire/Ceredigion not being available to undertake assessments/interventions.

Identify alternative venues/space to hold clinics (Integrated Psychological Services).	Marshall, Selina	~~31/07/2023~~ 31/11/2023	Rolling programme of groups being developed to enable additional clinical capacity within the service. some groups have already been implemented.
Identify alternative venues/space to hold clinics(Commissioning /CDAT).	Richards, Matthew	Completed	New North Dock premises are being progressed by APB to deliver new base in Llanelli with accessible clinic space. Currently going through planning and concerns about potential delays due to public objections. Due to a revision of the risk narrative, this action is no longer relevant and therefore noted as complete.
Directorate to transfer all service data collection processes to WPAS.	Amner, Karen	Completed	Delays to the Dementia Wellbeing Service, Integrated Autism Service, Perinatal, Memory Assessment Service migration delayed due to capacity within the Digital team to test and develop system at required pace. As at October 2023, all data for the relevant services noted on the risk have been transferred, therefore to close action.
Review workforce skill mix in light of any potential new funding received from WG for Neurodevelopmental services.	vaughan, Catherine	31/03/2024	Workforce reviewed and skill mix within team expanded to ensure a multidisciplinary approach in order to deliver an integrated multi disciplinary service in respect of the fixed term funding for 2023/24 received on behalf of the Regional Partnership board(RPB).

Monitor the use of SIFT monies for service development. The Director of Finance has given an undertaking that this will be funded as discussed and agreed at a Directorate Improving Together Session in April.	Carroll, Mrs Liz	31/03/2024	During the budget setting process in Month 7, the £575k for procurement for EMDR and ASD was not factored into the Directorate position despite this having been agreed following agreement at Public Board in September 2022. This was raised by the Finance Business Partner during the budget setting process with Finance colleagues. This leaves a deficit in this years budget. To be reviewed in the DITS meeting on the 27th October 2023.
As a result of Reinforced Autoclaved Aerated Concrete (RAAC) found at Withybush General Hospital site and the internal major incident that has been declared, some areas previously used by the Directorate have now been withdrawn. The Directorate attend the Outpatients RAAC Subgroup (Bronze) where the impact on the Directorate and potential solutions are being worked through in collaboration with the wider Health Board. Linked to Estates Risk 1711.	Carroll, Mrs Liz	29/03/2024	New action.
Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic TNA that can be reviewed at regular intervals and monitored for compliance.	vaughan, Catherine	30/11/2023	In progress, with update to be provided at next risk review

Appendix 3

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
Welsh Government performance indicators along with internal monitoring arrangements will be used to ensure the actions are having the desires effect or whether there is more that needs to be done.	Management monitoring of referrals	1st			Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC (Oct21) MHLD progress update on Planning Objective 5G - Board (Mar22) Papers have been presented at the Quality Safety and Experience Assurance Committee with a further update paper provided for the December 2021 meeting outlining control measures to manage the waiting times that the Directorate have at present. A paper was presented at Board Seminar in June 2022 to provide assurance on current waiting	System to improve analysis of patient experience	Outcome measures to be in place to measure effectiveness/quality of services provided (CAMHS & Psychological therapies).	Lodwick, Angela	Completed	S-CAMHS is implementing nationally agreed Welsh Government Outcome Measures - staff have received training as part of the Welsh Government Initiative. Gold Based Outcomes, SDQ and YP Core. Katie O'Shea has implemented this and all staff have received training and aware of expectations.
	Monthly MH&LD Business Planning and Performance Group overseeing performance	2nd					Outcome measures to be in place to measure effectiveness/quality of services provided(Adult Inpatient and Learning Disabilities Services).	Bassett-Gravelle, Ms Lisa	Completed	Due to staffing issues it has been difficult for the Business Manager to take further with the SALT team due to pressures within services. Business Manager is liaising with Sarah Mackintosh from Carmarthenshire People First with questions to go onto an easy read format. Meeting with Carmarthenshire People first on 17th April 2023 to go through the questions for the easy read format. Once easy read format has been completed Business Manager will take to Q&S Team to add a QR Code to give the service user the choice of both options. 15/06/2023 both easy read and electronic forms completed, meeting with CTLD managers taking place to roll out the new forms.

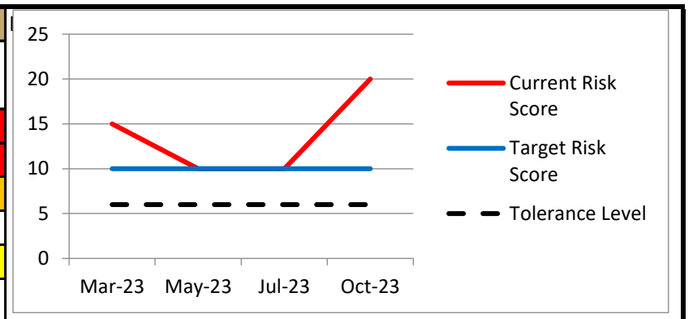
MH&LD QSE Group overseeing patient outcomes	2nd			times and control measures.		Outcome measures to be in place to measure effectiveness/quality of services provided(Commissioning /CDAT).	Richards, Matthew	Completed	CDAT outcomes measures are gathered using TOP assessment for all service users and reported via quarterly KPI's to APB and WG. Commissioning outcomes measures are being reviewed and recent work with NCCU will support this. Possibly pilot an outcome framework with NCCU as a temaplate for national approach. Due to the reframing of the narrative of this risk, CDAT is now out of scope therefore action completed
Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC	2nd								
W-PAS Internal Audit (reasonable assurance(	3rd								
An update was requested by the Chair and provided for the August Quality, Safety, Assurance Committee.									

Appendix 3

Date Risk Identified:	Nov-22		**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Oct-23
Strategic Objective:			**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Nov-23

Risk ID:	**1531**	**Principal Risk Description:**	There is a risk of being unable to provide a safe and sustainable general surgery consultant on-call rota at WGH. This is caused by vacancies and long-term sickness across the General Surgery Consultant rota (1:5) at WGH and reduced capacity to support rotas internally (BGH/GGH Consultants). This could lead to an impact/affect on the ability to continue general surgery at WGH, patient experience, clinical delays, deterioration, and outcomes for patients, the wellbeing of remaining consultants who are already working to full capacity and increased expenditure on agency locum consultants.
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):	4×5=20
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	↑



Rationale for CURRENT Risk Score:

The risk score has now increased, due to the uncertainty of finding and maintaining cover to ensure the rota does not collapse. The 1:3 model provided some assurance, however the GGH and BGH consultants are withdrawing from this model on 01/11/2023. The risk score could be decreased once a suitable Medacs locum is in place and recruitment of an NHS locum has taken place on 20/11/2023. Until then, we will be trying to maintain a 1:4 on call rota with 3 consultants. An informal meeting has been arranged with a Medacs locum candidate today.
The SBAR is currently being updated to reflect the current situation and will be presented at ALG on 01/11/2023.

Rationale for TARGET Risk Score:

The target risk score remains high due to the intended recruitment of a second NHS locum to fill the gap and maintain a 1:4 24/7 on call rota at WGH. However, this will not address the longer term sustainability of the rota and lack of substantive staff to fill the rota. This will prioritised as part of the development of the Clinical Service Plan in 2023/24.

Appendix 3

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**
One NHS locum consultant in post, a second is currently out to advert, closing date 20/11/2023. This still leave 3 consultants on the rota. Currently out to Medacs to fill the gap while recruitment takes place. One candidate was not suitable and an informal discussion has been arranged with a second candidate for today. Current staff from WGH and GGH backfill to maintain the rota. Continuously liaising with the rota coordinator at WGH for potential gaps on the rota. Proactive sickness management Escalation to clinical leads Engagement with WGH Medical Staff Committee and public on changes to services Board approval on 31Mar23 to introduce a contingency model of 1:3 rota to WGH with out of hours support from BGH/GGH from 01May23 All transfers are recorded and concerns managed appropriately.	The current 1:3 emergency week model is coming to an end from 01/11/2023, following the withdrawal of BGH and GGH consultants from the plan. The 3 WGH consultants have agreed to move to a 1:4 24/7 on call rota, but the 4th slot needs to be filled by a Medacs locum until recruitment of an NHS locum takes place. If we are unable to secure a locum by mid-November, we will be reliant on internal locum cover and the rota would be at risk of collapse. The locum consultant who started on 04/09/2023 was an associate specialist and part of the MG rota, this has now left a gap on that rota. Currently being covered by a Medacs locum and a replacement has been recruited, currently onboarding. Concerns raised about a transfer, which is being managed by an IMG process. Vacancies remain due to inability to appoint permanent Consultants to WGH. Due to the fragility of the on call rota there is limited elective capacity for locum consultants, which makes this post less attractive than other Health Boards. Reduced capacity to support this rota internally (BGH/GGH Consultants). Prolonged change to rota may impact on training of surgical doctors in WGH. Concerns from WGH physicians on the wider implications on the emergency service model at WGH	Recruitment of 2 x substantive and 1 x locum positions	Lewis, Caroline	20/11/2023	One NHS locum has been recruited and has been in post since 04/09/2023. Currently out to advert for a second NHS locum (following a previous withdrawal of application) Interviews are due to take place on 20/11/2023.
		To introduce a contingency model of day time consultant on-call rota in WGH with support from GGH and BGH consultant cover out of hours.	Lewis, Caroline	Completed	Report discussed at Acute Leadership Group, Executive Team and Operational Planning and Delivery Programme (OPDP) meetings. A 1:3 rota was agreed and will commence from 01May23.
		Review the longer term sustainability of general surgery on-call rotas across Hywel dda (recommendation from Getting it Right First Time (GIRFT) review in Jan23)	Lewis, Caroline	31/12/2023	We have now received the final GIRFT report and the action plan has been received at executive level. A full action plan is now supported and clinically led by the health board general surgical clinical lead, nursing and operational teams.
		Robust plans to be developed for transfer and repatriation of patients	Lewis, Caroline	Completed	SOP has been developed and discussed with clinicians.

Appendix 3

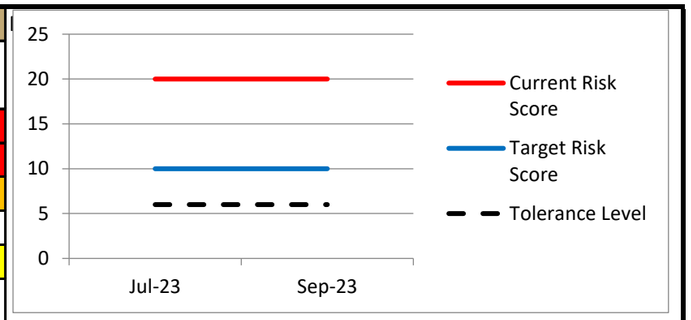
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES			
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	WGH Medical Staff Committee established to develop models of sustainability	1st			Management team have presented an SBAR to Acute Leadership Group (Feb23) SBAR to Executive Team and OPDP to agree 1:3 rota (Mar23) General Surgery Report to Board (Mar23) Management team to present updated SBAR to Acute Leadership Group (Oct23) Management team to present updated SBAR to Acute Leadership Group (Nov23)	Assurance to Board on communication and repatriation arrangements	Produce update report to Board in May23 to include details on communications with clinicians and the public, details of repatriation arrangements and accommodation and support for families, the patient experience and the governance arrangements for onward scrutiny	Lewis, Caroline	Completed	on 10/05/2023, an update was provided to Ben Rogers of the clinical services programme for the draft SBAR clinical services update which is what was taken to board.
	Reported to monthly General Surgery Business Meetings on each site (BGH/GGH/WGH)	2nd								
	Reported to bi-monthly Scheduled Care Quality, Safety and Experience Group through exception reporting	2nd								
	Assurance to be reported to the Board following introduction of temporary rota	2nd								
	GIRFT report on General Surgery which raised the sustainability of general surgery across 3 sites in Hywel Dda - final report awaited(3rd,									

Appendix 3

Date Risk Identified:	May-23	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Oct-23
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Nov-23

Risk ID:	**1664**	**Principal Risk Description:**	There is a risk to service sustainability in Ophthalmology across the Health Board, and the inability to provide timely care to patients with Glaucoma, wet Age Related Macular Degeneration (wAMD), and Cataracts. This is caused by a national shortage of Consultant Ophthalmologists and the inability to recruit to vacancies. The workforce position is exacerbated by nursing and medical staffing constraints and a reduction in service capacity due to lack of physical space, and long-term funding. Recruitment difficulties are leading to the Consultant on-call rota being covered by three substantive Consultants and a high cost Locum Consultant (Medacs) to ensure the delivery of the Ophthalmology service. This is a fragile on call structure which is impacted by sickness and annual leave. This could lead to an impact/affect on the Health Board's ability to deliver services within the Ophthalmology Referral to Treatment (RTT) plan, and delays in the NICE guidance 14-day pathway for AMD appointments, impacting on the ability to provide timely diagnosis and treatment and directly impacting on patient safety with the potential for sight loss and long-term lifestyle impacts. This will also affect the Health Board's ability to comply with Welsh Government Eye Care Measures (ECMs), and service pressures are impeding on the Health Board's ability to progress with the implementation of recommendations raised by various regulators and inspectorates. This in turn could lead to adverse publicity and reduction in stakeholder confidence, with increased scrutiny/escalation from Welsh Government. Workforce pressures could also impact staff well-being and morale.
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):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	*NEW RISK*



Appendix 3

Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for patients most at risk with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. The service has provided additional AMD sessions on a weekend, however these additional sessions have not been enough to meet the demand across all counties in the Health Board. Patient delays continue across the HB. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience. The current non-medical workforce establishment is not aligned to service needs. Additional staffing for Wet AMD was incorporated into IMTP but no funding was allocated. The service currently has 5713 patients that have been 100% delayed for their follow up appointment. The total New patient referrals is at 5492 of which 403 are breaching 52 weeks (the longest wait from this cohort is 67 weeks). 3785 patients are awaiting an Ophthalmic operation of which 24 are breaching 104 weeks (the longest wait from this cohort is 120 weeks). The current impact has been scored as 5 because patients suffering irreversible sight loss or damage is a reality and the current Likelihood has been scored 5 as Ophthalmology is a fragile service. It is unlikely that we will be able to achieve the Board tolerance score of 6 without a regionally agreed solution.	It is unlikely that the service will be able to reduce the impact score of this risk as the consequences to the patient remains high, however due to recent re-structuring of the management team within Ophthalmology it is hoped that this will provide opportunities to review and improve service delivery with an initial focus on meeting eye care measure targets for the most high risk cohort of patients. The recent addition of a substantive WTE Consultant will help to address the longest waits. A Regional Consultant post has been recruited in Swansea bay to provide an additional 10 sessions a week in HDUHB. With the above additional workforce and focused management of the waiting lists, HDUHB will potentially help to reduce the likelihood score on this risk.

Appendix 3

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**
Active recruitment to vacancies, x1 substantive Consultant has recently been appointed. X1 WTE post secured with Swansea Bay and x1 substantive Consultant post to go out to advert. Regional Business Case for a South West Wales Glaucoma Service. Regional discussions regarding a South West Wales Consultant On-call provision. Additional weekend working to provide Wet Age related Macular Degeneration (AMD) capacity. Currently funded for x2 all day lists per month. Lists cancelled due to AL are offered out to backfill. Review of service rota undertaken by Clinical lead to ensure stability to existing team and robust cover of emergency work. Identification of patients suitable to undergo Community Glaucoma data capture and virtual review by Consultant Ophthalmologists. Full Business Case for OpenEyes software (National Electronic Patient Record for Ophthalmology) approved and funding for this project has been secured for 1.0 WTE Band 7 project manager and a 0.5 WTE band 5 application support manager. This project is being aligned with SBUHB. ARCH Glaucoma workstreams in place. Validation taking place through scheduled care validation team. Clinical validation of all HCQ patients to be undertaken by nurses (documentation has been approved for a pilot to start in November 2023). Eye Care Collaborative Group meets quarterly to oversee performance against eye care standards. ECM Coordinators in place. Review of data quality inclusive of HRF code and clinical codes ongoing to improve data quality. 7 prescribing hubs have now been set up across the Health Board, with the aim to reduce the number of patients requiring Secondary Care Eye Services, ensuring those with the need for secondary care intervention are referred. Highly trained Optometrists working collaboratively with the Secondary	Whilst recurring money has been invested into glaucoma and cataract services there still remains areas of the service (e.g. AMD, VR, plastics) that require investment. Regional clinical workshop to consider opportunities for a long-term regional model are needed. There is a pan-Wales clinical view that central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service. Recovery funding was in place until March 2023. Transformational funding from Welsh Government is in place until March 2024. Actions have assisted the backlog number of patients waiting to be managed in subspecialties such a Diabetic Retinopathy however other high volume areas such as AMD and Cataracts continue to see growth in waiting times. There are concerns in data quality due to referral processes and system use. The Ophthalmology service has continued to recruit over budget to sustain current services.	Regional discussions to be arranged as a priority around Ophthalmology services to support a long-term sustainability plan for eye care services.	Coppack, Victoria	~~30/09/2023~~ 31/12/2023	Outline discussion around regional support for a workforce development plan for HDUHB multi-disciplinary team development. Regional working for Open eyes digitalisation.
		Root and branch review of operational, workforce and sustainability models .	Coppack, Victoria	~~30/06/2001~~ ~~31/03/2022~~ ~~31/10/2022~~ 31/12/2023	Root and branch review to be undertaken through ARCH group. Regular meetings need to be undertaken for Glaucoma and Workforce plan.
		Roll out and implementation of National Electronic Patient Record for Ophthalmology.	Barreiro, Marta	~~30/07/2021~~ ~~07/06/2021~~ ~~31/10/2021~~ ~~31/03/2022~~ ~~31/05/2022~~ ~~30/09/2022~~ ~~31/10/2023~~ 31/12/2023	Issues identified in the planning phase around data governance. DHCW are working to resolve issues and will provide an update end October 2023. The launch of EPR could be as far as 2025. Regional planning scoped and aligned programme now established with Swansea Bay UHB.
		Refurbish and establish a nursing team in the Outpatient Department in Amman Valley Hospital to provide intravitreal treatment for the patients currently attending the day theatre area for their treatment. This will ensure continuity of care for those patients when cataract surgery activity is returned to day theatre.	Coppack, Victoria	~~31/01/2022~~ ~~31/03/2022~~ ~~30/04/2022~~ ~~30/09/2022~~ ~~31/10/2023~~ 31/01/2024	Capital bid was secured and work to improve physical space at Amman Valley Hospital (AVH) has been completed since March 2022. Recruitment into nurses posts to support out-patient activity has delayed move to out-patient area. Scoping project to be undertaken to look at undertaken Consultant led eye implants/complex patients through this out-patient space. This is currently on hold due to the space being utilised for WGH Ophthalmology patients (RAAC)

Care Eye Service to reduce referrals to secondary care. Continued training of Optometrists within secondary care to continue to develop this service. ARCH workstreams in place- looking at Glaucoma and funding has been secured to support this development. ARCH support around Diabetic retinopathy and cataracts has been completed and pathways are in place. Ongoing arrangement of Optometrists enrolling in prescribing training. Weekly monitoring of each sites AMD demand and capacity to allow for recovery planning of breaching patient waiting times.			
Plan for Glaucoma pathways to be implemented through ARCH.	Barreiro, Marta	~~30/06/2022~~ ~~31/10/2023~~ 30/11/2023	Business case has been approved and pathway has been implemented with support from Swansea Bay Consultant. ODCT pathway x2 has been developed, Optometrists virtual pathway for Glaucoma A patients starting in November 2023.
Recruitment of approx. 7 nursing staff and 2 technicians.	Barreiro, Marta	~~30/06/2022~~ ~~31/10/2023~~ 31/12/2023	2.0 WTE Technicians secured 0.8 WTE Glaucoma practitioner secured. 3.3 WTE Nurses secured Outstanding 1.9 WTE Glaucoma practitioner and 1.0 WTE Nurse which have not been recruited into.
Recruitment drive for Glaucoma Consultant.	Barreiro, Marta	~~30/09/2022~~ 30/09/2023	x2 Consultants secured through Swansea Bay. X1 WTE equivalent to work in HDUHB. Job plan agreed with start date 20th November 2023.
Remodelling the capacity and demand associated with Wet AMD and Amman Valley	Coppack, Victoria	~~31/03/2023~~ ~~31/10/2023~~ 30/11/2023	Ongoing costs associated with additional activity. Pathway review to be presented in SBAR in view of recent demand and capacity work completed to inform this paper.
Recruitment of theatre staff and admin support to enable the optimisation of AVH theatres for cataracts.	Barreiro, Marta	~~31/03/2022~~ ~~30/08/2022~~ ~~31/10/2023~~ 30/11/2023	Inability to recruit additional theatre staff has prevented the increase from 2 days a week theatre. To be reviewed with theatre Sister to develop action plan. IVT plan may release capacity for further cataract surgery. To be scoped in SBAR.

Devise and approve plan for Diabetic retinopathy service through ARCH.	Barreiro, Marta	~~30/06/2022~~ ~~07/09/2023~~ 30/11/2023	Funding was secured through transformational bid. Carmarthenshire and Pembrokeshire have secured timeliness of patient appointments for follow up and new patients. Ceredigion has been more challenging due to lack of Optometrist uptake. Aberaeron integrated care centre has now been secured for x1 session per week supported by a technician.
Plan for Cataracts pathway to be implemented through ARCH.	Barreiro, Marta	~~30/06/2022~~ ~~30/09/2023~~ 30/11/2023	Locum Consultant secured to assist with delivery of Cataracts surgery/Substantive Consultant with specialism in plastics secured who can also undertake cataract surgery. Review of Demand and Capacity now undertaken to inform service recovery.
Implement virtual review clinics for patients undergoing Hydroxychloroquine (HCQ) treatment.	Coppack, Victoria	~~30/09/2022~~ ~~31/10/2023~~ 30/11/2023	Validation of HCQ patient being scoped. Longest wait HCQ patients have been identified. Virtual review process to be discussed with Clinical lead. Clinic spaces to be secured for patient review. This is an interim measure whilst community hub is being developed.
Clinical validation rota to be established within the service to ensure validation of high risk patients and longest waits is undertaken to prioritise patient reviews and safety net patients	Coppack, Victoria	~~30/09/2023~~ 31/12/2023	Validation ongoing and R1/longest wait patients booked in terms of their priority for next quarter.
A sustainable model for AMD to be developed with continued support from performance team.	Coppack, Victoria	~~31/10/2023~~ 30/11/2023	Demand and capacity planning for IVT service undertaken and detailed SBAR to be drawn up.

Appendix 3

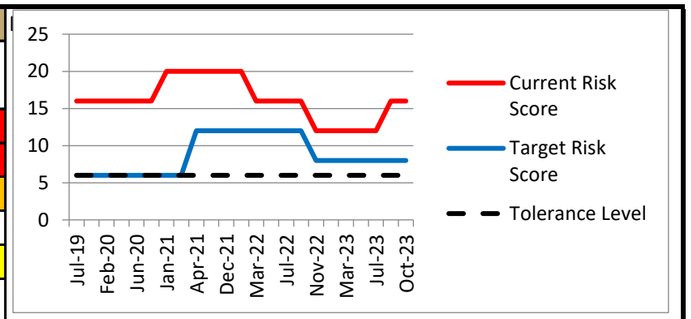
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Eye care measures monthly report.	WPAS	1st								
GIRFT review Cataracts.	GIRFT action plan cataracts	1st								
GIRFT review Glaucoma.	GIRFT action plan Glaucoma	1st								
Watchtower review of ministerial measures	WPAS, scheduled care performance indicators	1st								

Appendix 3

Date Risk Identified:	Jan-19	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Oct-23
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Nov-23

Risk ID:	**684**	**Principal Risk Description:**	There is a risk to the radiology service provision from breakdown of key radiology imaging equipment. This is caused by equipment not being replaced in line with RCR (Royal College of Radiologists) and other guidelines. This could lead to an impact/affect on patient flows resulting from delays in diagnosis and treatments, delays in discharges, increased waiting times on cancer pathways, increased staffing costs to minimise the impact on patients when breakdowns occur and increased number of breaches over 8 weeks due to increased downtime.
Does this risk link to any Directorate (operational) risks?		925, 114	

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):	4×4=16
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	6
Trend:	↑



Rationale for CURRENT Risk Score:

The Health Board's stock of imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites which has a significant impact on the Health Board's ability to meet its Referral to Treatment (RTT) target and impact to patients can include delays in diagnosis and treatment. CT and MR scanners have been replaced and has reduced the frequency of machine downtime compared to previous experience.

The risk score is noted as 16 reflecting that some equipment has been installed and is operational, however further investment required given recent breakdowns of key imaging equipment. A costed plan along with a rolling programme for the installation of additional equipment is in place. The next batch of equipment for replacement has been prioritised and identified, however funding has not been secured (for financial year 2023/24). As at September 2023, confirmation on funding is awaited.

Gamma camera at Withybush General Hospital is the only scanner of its nature in the Health Board, and has experienced a breakdown in August 2023 due to intermittent failures which resulted in several HIW reportable IRMER incidents. This item of equipment is on the current priority list of items to replace as at September 2023.

While a new CT scanner has been obtained and installed at Glangwili, the original CT scanner has had a number of breakdowns due to its age. The technology on this scanner is also now out of date, and impacts directly on the resilience of the service at our major trauma site in the Health Board.

Rationale for TARGET Risk Score:

While equipment has been installed as part of the current WG funding allocations, there is uncertainty as at November 2022 with regards to continued equipment replacements for financial year 2023/24 due to the discontinuation of a dedicated imaging equipment replacement allocation. New All Wales PACS procurement requires all equipment to be DR for compatibility. This has meant that replacement priorities have changed, and that some of the older DR compliant equipment are now overdue for replacement, and at risk of being de-prioritised.

With more modern equipment, breakdowns will be less likely and less significant in terms of downtime together with a reduced impact on the diagnostic services at the remaining hospital sites. Improved business continuity plans will also help reduce the impact of equipment breakdown across the UHB.

Appendix 3

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**
# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg daily checks). # Use of other equipment/transfer of patients across UHB during times of breakdown. # Ability to change working arrangements following breakdowns to minimise impact to patients. # Site business continuity plans in place. # Disaster recovery plan in place. # Replacement programme has been re-profiled by risk, usage and is influenced by service reports. # Escalation process in place for service disruptions/breakdowns. # Newly created National Imaging and Capital Priorities Group ensures there is a robust governance process to support a national, sustainable clinically focused capital equipment programme across Wales. This will ensure that all HB's in Wales agree to a prioritisation process which will allow for timely equipment procurement and delivery to support healthcare demands across Wales.	Limitation of spare parts for some older equipment leading to extended outages. This issue may be compounded by Brexit. Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites. Reliance on AWCP for replacement of equipment. Competing demands for replacement equipment due to RISP, as four pieces of equipment will be non-compliant No dedicated diagnostic equipment replacement funding has meant that DCP bids are having to be developed for all equipment replacement. National Imaging and Capital Priorities Group held its first meeting in September 2023 therefore in its infancy, and has a further work required to ensure a fair and robust process is undertaken to appropriately assess all imaging modalities and which understands individual HB risks to equipment replacement.	To confirm the capital funding to replace existing aged equipment for FY 2023/24	Roberts-Davies, Gail	~~31/03/2023~~ ~~30/06/2023~~ 31/12/2023	A prioritisation list of aged equipment to be replaced has been devised, however confirmation needed on funding in order to undertake the required work. Still awaiting funding outcomes as at Setpember 2023.
		To confirm funding arrangements for the remaining equipment that needs to be replaced, supported by individual DCP bids or dedicated replacement funds for 2023/24.	Roberts-Davies, Gail	~~30/09/2023~~ 31/12/2023	Directorate has compiled a list of equipment requirements, which have been prioritised dependant on finance availability and functionality of the existing equipment and presented at Capital Sub-Committee in September 2023. Priority list has also been submitted to the National Imaging Equipment Capital Priorities group (NHS Executive Group) via assessment process, with outcomes currently pending as at September 2023.
		Installation of replacement Gamma Camera, WGH	Roberts-Davies, Gail	31/03/2024	Gamma camera is 9 years old and the only scanner in the Health Board providing a regional service. Recurrent breakdowns are resulting in HIW reportable incidents. Awaiting confirmation of funding as at October 2023.

Replacement of CT Scanner at GGH	Roberts-Davies, Gail	31/03/2024	CT scanner is 11 years old, with increased failures noted and that new technologies are now available. Awaiting confirmation of funding as at October 2023.
Replacement of digital x-ray rooms at Tenby Cottage Hospital and South Pembrokeshire Hospital	Roberts-Davies, Gail	31/03/2024	Ageing equipment with numerous breakdowns. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. Awaiting confirmation of funding as at October 2023.
Replacement of ultrasound systems at BGH & GGH, image intensifier units at BGH & WGH, and Vacuum Assisted Biopsy (VAB) unit for PPH Breast Clinic	Roberts-Davies, Gail	31/03/2024	Ageing equipment with replacements required for obstetric scanning, and resilience of services provided to Theatres. Awaiting confirmation of funding as at October 2023.
Replacement of Fluoroscopy room, WGH	Roberts-Davies, Gail	31/03/2024	Equipment is 17 years old with significant downtime experienced. Awaiting confirmation of funding as at October 2023.

Replacement of CR A&E DR room and OPT (Dental) units, BGH	Roberts-Davies, Gail	31/03/2024	Ageing equipment, with the dental unit 26 years old. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. Awaiting confirmation of funding as at October 2023.
Replacement of CR X-ray Room 1, WGH	Roberts-Davies, Gail	31/03/2024	Ageing equipment. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. Awaiting confirmation of funding as at October 2023.
Replacement of Digital X-Ray room, Llandovery Hospital	Roberts-Davies, Gail	31/03/2024	Equipment on site is incompatible with the incoming PACS system, and interim solution required. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. Awaiting confirmation of funding as at October 2023.
Replacement of Mammography Units, BGH and WGH	Roberts-Davies, Gail	31/03/2024	Ageing equipment, exacerbated by the failure of Secureview. Awaiting confirmation of funding as at October 2023.
Upgrade or replacement of MRI scanner, PPH	Roberts-Davies, Gail	31/03/2024	Ageing equipment with increasing failures, with new technologies now available. Awaiting confirmation of funding as at October 2023.

Upgrade or replacement of MRI scanner, GGH	Roberts-Davies, Gail	31/03/2024	Ageing equipment with increasing failures, with new technologies now available. Awaiting confirmation of funding as at October 2023.
Replacement of Room 3 (Digital x-ray room), BGH	Roberts-Davies, Gail	31/03/2024	Mobile unit currently being used. Awaiting confirmation of funding as at October 2023.
To consider alternative funding options for the DEXA unit, BGH	Roberts-Davies, Gail	31/03/2024	Unit is 17 years old, and previously funded via charitable funds

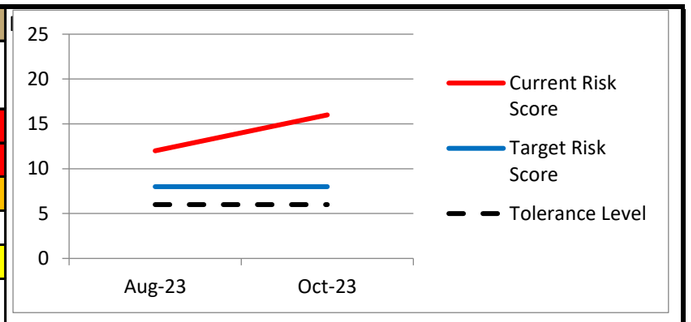
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES			
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Reduction of waiting times to under 6 weeks by Mar22. Reduction in overtime costs to nil by Mar22.	Monthly reports on equipment downtime and overtime costs	1st			Radiology Equipment SBAR - Executive Team - Mar19 Further updates CEIMT Feb20 Further updates CEIMT Sep20	Lack of process of formal post breakdown review.				
	IPAR report overseen by PPPAC and Board bi-monthly	2nd								
	Internal Review of Radiology Service Report (Reasonable Rating	3rd								
	WAO Review of Radiology - Apr17	3rd								
	External Review of Radiology - Jul18	3rd								

Appendix 3

Date Risk Identified:	Jul-23		**Executive Director Owner:**	Paterson, Jill	**Date of Review:**	Oct-23
Strategic Objective:			**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Nov-23

Risk ID:	**1708**	**Principal Risk Description:**	There is a risk of increasing fragility in Primary Care Contractor services. This is caused by challenges in recruiting new clinicians into salaried or partnership roles which impacts on succession planning for contractor professions. There are further challenges in relation to premises not being fit for purpose and not having the capacity to flex to a more modern approach to service delivery e.g. MDT working. In addition, contract reform against the background of significant pressures on the wider system, and exacerbated by financial pressures for the independent contractor business model. This could lead to an impact/affect on undermining the independent contractor model, and therefore the ability for patients to access timely and local primary care services. If service users are unable to access these services, this may lead to additional pressures on other primary care services, and wider Health Board services such as Out of Hours and Urgent and Emergency Care. As a result of contract terminations, there will be a detrimental impact on the financial position of the directorate relating to dental contracts.
Does this risk link to any Directorate (operational) risks?		1688, 1451, 1403, 1164, 1660, 933	

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	6
Trend:	*NEW RISK*



Appendix 3

Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
As at October 2023, 8 dental contracts and 3 GMS contract has been returned to the Health Board in the last 12 months. This has resulted in 25,000 dental patients being displaced. In addition, a further 8 dental practices have not signed up to the contract reform, and signalling that they will return contracts once reform negotiations have concluded. 2 out of the 3 GMS contracts have become Health Board managed practices, resulting in additional financial pressures as the workforce is salaried, and third practice is going through the vacant practice process. It is recognised that any further managed practices would likely have a negative impact on the GMS budget. The number of complaints received from the public has increased due to returned contracts, and while the Health Board is currently containing the demand for urgent dental care, it is recognised that patients who don't fall in to this category but require a level of dental care are detrimentally impacted, and that any further contracts returned will exacerbate this situation. The capacity of the Health Board in terms of staffing to absorb further contract reform will impact on the ability to effectively deliver services, and a detrimental impact on staff welfare. With new contract implementation relating to Optometry due in January 2024, there is an expectation of a shift from hospital care to the community, however the model is untested in terms of contractor capacity and skill set. Due to the above, the current risk score has been increased to 16.	Achievement of the target score is subject to the development and agreement of a Primary Care Strategy at Board alongside successful national contract negotiations and subsequent implementation across the Primary Care contractor professional groups.

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**
Primary Care Academy in place, which looks at workforce planning, training and development needs and opportunities 5 Facet Survey completed in 2022 to establish a baseline for the GMS estate GMS and Dental Practices undertake annual reporting which includes reviews of statutory compliance requirements	A series of patient facing videos have been developed with Pocket Medic to support patient education in accessing Primary Care Services. Requests for support on addressing the GMS sustainability agenda are with the Strategic Programme for Primary Care as a result of a review	Establish workforce plan and recruitment strategy in line with the development of the national Primary Care Workforce Strategy and as a component of the Primary Care Strategy.	Hughes, Samantha	31/03/2024	Workforce planning continues

Appendix 3

0.25 FTE Primary Care Development Manager for estates in post but with a focus on GMS Escalation tool for GMS and Community Pharmacy (SITREP) Continue effective engagement with struggling practices to support with their issues through close working relationships developed with practices. Programme of practice visits to review Estates provision, and if remedial action is required Nationally agreed Breach Management process in place for Community Pharmacies. Requests for contract variation (termination, merger, branch surgery closure etc) are considered in line with national guidance, with panels convened as stipulated. Recommendations are taken through the Primary Care Contract Review Group with papers to Board when required.	Primary Care as a result of a review paper across all Health Boards on their sustainability pressures. National work on the development of the escalation tool for Dental and Optometry is ongoing but not live. Five Facet Survey and annual reporting of practices has highlighted non-compliance with statutory requirements such as Health and Safety, Fire and IP&C which have now all been addressed. Limited requirements for practices to disclose information to the Health Board about their sustainability pressures, and rare for practices to disclose financial details (reliant on engagement and good will as this is not a contractual requirement as at June 2023). Insufficient resources to support the estates development across all Primary Care services, particularly with independent contractors. Whilst Community Pharmacy Breach Management process in place, 2 notices are currently under the appeals process - the Health Board is awaiting confirmation on the outcomes of these by Welsh Government, which to date has taken 10 months. Outcomes of these appeal will directly influence the approach taken going forward, and may result in the natioanlly agreed process unable to be fully implemented.	To develop the Primary Care Strategy in consultation with statutory stakeholders and consultees, to cover areas including: •Workforce •Sustainable provision of Primary Care services •Estates •Managing contractual change •Developing pathways and new services •Improving access to services across all contractor professions	Bond, Rhian	30/09/2024	Paper submitted to Board in September 2023 setting out the scope of the Primary Care Strategy, with a further paper to be presented at Board in January 2024.
		Consider the potential to deliver a wider range of salaried NHS Dental Services through the Community Dental Service.	Owens, Mary	30/04/2024	Modelling is ongoing.
		Implement the Managed Practice Strategy plan will give greater system resilience.	Swinfield, Anna	30/04/2024	Currently progressing the tender action for Neyland and Johnstown practice, anticipating contract award by April 2024.

Appendix 3

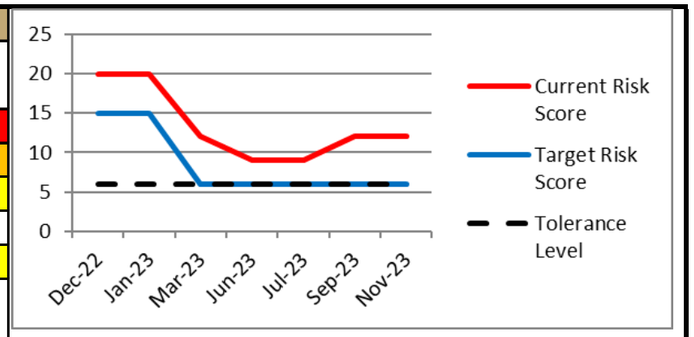
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Sustainability Matrix Contract performance to monitor volume metrics (identifies if dental practices have issues in service delivery) Monthly assurance reports and Dental Assurance Framework - Business Service Authority dashboards, to identify outliers	GMS practices are asked to complete a WG sustainability matrix every 6 months to track the main risk areas and this contributes to a heatmap. Practices are also asked to report regularly on operational pressures	1st			OQSEC Primary Care Exception Report (Jun 23)	Varying levels of engagement from practices in the regular reporting of operational pressures.				
	Dental Management Team undertake annual reviews	1st								
	GMS Practices are part of a rolling visiting programme, based on their annual return which is risk assessed against a framework of any other issues or concerns identified	1st								

Appendix 3

Date Risk Identified:	Nov-22	**Executive Director Owner:**	Gjini, Ardiana	**Date of Review:**	Nov-23
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Jan-24

Risk ID:	**1548**	**Principal Risk Description:**	There is a risk of the Health Board being unable to maintain routine, urgent and emergency service provision across the organisation in the event of industrial action by Health Board staff and staff in other NHS/partner organisations, eg Welsh Ambulance Service Trust (WAST). This is caused by the British Medical Association (BMA) initiating the process to commence industrial action. This could lead to an impact/affect on patient care, patient safety, delivery of services and organisational reputation. Additionally this could also impact delivery of the Health Board's delivery plan, waiting lists (and associated initiatives) and financial position.
Does this risk link to any Directorate (operational) risks?		1027, 1407, 1550, 1641, 1666	

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):	4×3=12
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	6
Trend:	↑



Rationale for CURRENT Risk Score:

The Royal College of Nursing (RCN) and the Society of Radiographers have accepted the enhancements to the non-pay elements of the pay offer. This concludes the Industrial Action for A4C staff. However, the British Medical Association (BMA) have declined an offer of 5% uplift (1.5% uplift for Junior Doctors including SAS Doctors) for 2023/24 to basic pay. Ballot notices have been received by employers (both Hywel Dda UHB and NWSSP) detailing that the ballot to members has commenced and will end on 18 December 2023. This applies to Junior Doctors only. The BMA are expected to reach the 50% threshold for action. Welsh Government (WG) have been notified of the dispute directly by the BMA.

Mitigation and contingency measures, together with command and control structures put in place during periods of previous action by Trade Unions resulted in a co-ordinated response to minimise impact as far as possible, and this has been re-established. The risk score remains the same until the ballot results have been notified to both employers. If the threshold is indeed reached, the BMA have advised that they intend to take an initial 72 hours consecutive period of industrial action in the new year. No formal notification has been received relating to the Consultants to date.

Rationale for TARGET Risk Score:

The likelihood has been increased as the BMA has commenced the formal notification process of intention to ballot. Executive ownership is joint (Directors of Public Health, Workforce and Operations) but will be supported by the Medical Director and Director of Nursing, Quality and Patient Experience as required.

Appendix 3

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**
Industrial Action Planning Group formed for planning, developing contingency measures and response arrangements. Command & Control structures in place at local, regional and national level. Proactive compilation of critical service areas from a HB perspective (based on Essential Services Guide) completed. Process developed for scoping scale of staff intentions to take industrial action in place. Process developed for scoping of staff groups in planned action in place. Data capture process in place to determine impact on service delivery, patient care and financial position. Process for measurement of "harm" agreed. Communication strategic approach agreed with staff FAQs, public communications, internal staff communications and partner agencies. Guide for line managers and staff on understanding the derogation process and response developed. Range of contingency measures ready should any derogations be refused. Medical representation secured for the Industrial Action Planning Group All Wales Industrial Action Workforce Cell re-established.	Clarity regarding the intentions of the BMA until the ballot notices are received.	Specific response plans will be developed following notification from the B,A on dates they intend to take strike action on. These will include early contact with BMA; derogation process; student arrangements; and links to national process. The updating of previous key controls will be instigated as necessary to prepare for potential actions	Gjini, Ardiana	~~05/06/2023~~ ~~21/08/2023~~ 05/11/2023	Will make initial preparations and further progress as and when strike dates announced.
		To secure medical representation on Industrial Action Planning Group	Gjini, Ardiana	Completed	Complete, and added to control measures of the risk.
		To confirm new chair and vice chair of Industrial Action Planning Group	Gjini, Ardiana	~~30/09/2023~~ 03/01/2024	Progress to be provided at next risk review

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**
	Industrial Action Planning Group Meeting regularly	1st								
	Regular updates to Executive Team and OPDP	1st								