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:	08 August 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 Ardiana Gjini, Executive Director of Public Health Lisa Gostling, Executive Director of Workforce and OD
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

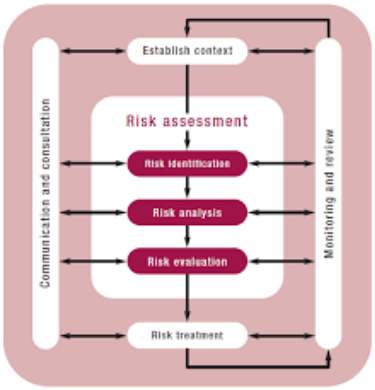
ADRODDIAD SCAA
SBAR REPORT

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 account 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 account the validity and reliability i.e. source, timeliness, methodology behind its generation and its compatibility with other assurances. This will enable the Board to place greater reliance on assurances, if they are confident that they have been robustly scrutinised by one of its Committees; and provide them with greater confidence 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 18 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 (April 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 risks	9	
New risks being reported	3	*See note 1*
De-escalated/Closed risks	2	*See note 2*
Increase in risk score ↑	0	
Reduction in risk score ↓	3	*See note 3*
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		1531 (NEW)			
MAJOR 4			684 (→) 1559 (→)	129(→)	1699 (NEW) 1032 (→) 1027(↓) 797 (NEW)
MODERATE 3			1548 (↓)		
MINOR 2					
NEGLIGIBLE 1					

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

Risk Reference & Title	Date risk identified	Lead Director	Current risk score	Update	Target Risk Score
1699 - Risk of loss of service capacity at WGH due to surveys and remedial work relating to RAAC NEW	13/06/23	Director of Operations	**5x4=20** (Reviewed 25/07/23)	Inpatient elective surgery as would ordinarily be delivered from Ward 9 on site are currently suspended as of June 2023. Surveys undertaken on Ward 12 have identified urgent remedial work to be undertaken, and the ward as of July 2023 is empty. The Estates and Facilities Directorate are currently undertaking risk assessments on the wards which have yet to be surveyed to determine the impact on staff and patient safety.	**2x5=10**
797 - Risk to the ability to deliver ultrasound services due to workforce pressures ESCALATED 09/05/23	07/11/19	Director of Operations	**5x4=20** (Reviewed 20/07/23)	Despite best efforts, the service remains fragile and supported by long term agency staff. Vacancies remain unfilled, with the inability to recruit despite repeated recruitment attempts. Long term vacancies exist in Bronglais General Hospital (BGH), Prince Philip Hospital (PPH) and Withybush General Hospital (WGH) - in particular in terms of modality lead sonographers at WGH in July 2023. A secondment is currently underway at PPH. There are a number of expected retirements and planned maternity absences in the near future. There will also be the inability to secure agency staff from July 2023 at WGH. As a result of the loss of ultrasound modality leadership in the team at WGH, this is resulting in reduced ability to undertake governance and audit	**3x4=12**

				requirements. A midwife has recently qualified after receiving sonography training at WGH in April 2023, and a further trainee qualified at PPH, however has since gone on maternity leave. More sonographers are due to be trained from January 2024. However, difficulties remain in obtaining locum staff, exacerbated by registration requirements. As at July 2023, the Radiology directorate have four adverts for differing sonography roles across the Health Board, ranging from leadership in sonography and training, with vacancies open until September 2023.	
1531 - Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures ESCALATED 20/04/23	10/11/22	Director of Operations	**2x5=10** (Reviewed 11/07/23)	The current risk score has been reviewed in July 2023, and remains the same to reflect the Board decision in March 2023 to introduce a one in three consultant on-call rota at WGH. There are currently two substantive consultants on the rota and one locum. Since the introduction of the out of hours pathway, there have been limited transfers to date. The new rota is under constant monitoring and review to ascertain and address any issues. There is continued concern raised regarding the travelling time for a transfer to BGH out of hours.	**2x5=10**

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

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

	escalated				
1349 - Ability to deliver ultrasound services at WGH	09/05/23	Director of Operations	**5x4=20**	The Executive Risk Group agreed to de-escalate this risk has to operational level when it escalated 797 above in recognition that the fragility of ultrasound services extended across the Health Board.	**3x4=12**
1340 - Risk of avoidable harm for HDUHB patients requiring NSTEMI pathway care	05/07/23	Director of Operations	**3x4=12**	The Executive Risk Group on 5 July 2023 agreed to de-escalate this risk following the reinstatement of the PPH Treat and Repatriate Pathway in April 2023 which has positively impacted on the management of this risk. The risk was also discussed at the Improving Together session held in June 2023. Performance will continue to be monitored by the service.	**1x4=4**

Note 3 – Reduction in risk score
The following 3 risks have had a reduction in risk score since the last meeting.

Risk Reference & Title	**Date risk identified**	**Lead Director**	**Current risk score**	**Update**	**Target Risk Score**
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 28/07/23)	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	**3x4=12**

				escalation across our acute sites on a daily basis. During recent months, increased levels of COVID-19, Influenza, respiratory disease and norovirus has placed additional pressure on available capacity. 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, and remains as such in July 2023.	
129 - Risk to the ability to deliver urgent Primary Care OOH Service due to current service model and recruitment difficulties	01/04/17	Director of Operations	**4x3=16** (Reviewed 19/07/23)	Fragility of out of hours (OOH) service delivery continues. Rotas continue to be fragile, particularly at weekends and holiday periods. The inability to recruit GPs, caused primarily by an aging workforce, combined with increased demand for face-to-face, longer complex consultations, and increasing pressures in day-to-day primary care which is impacting the ability of GPs to be available for OOH shifts. In addition, some clinicians may preferentially work in other urgent emergency care initiatives such as 111 First or Same Day Emergency Care (SDEC), as they are potentially much lighter (a	

				pattern reported by Swansea Bay University Health Board (SBU HB) OOH service). This is exacerbated by the minimal numbers of newly qualified GPs applying or enquiring about OOH working patterns. Any further absence on OOH provision is likely to result in further deterioration of the current position. The Health Board currently has approximately 43 GPs (compared to 100 5 years ago) who regularly work the rotas, and an additional 10-20 who only work bank holidays rotas due to enhanced rates. Advanced Nurse Practitioners (ANP) staff have reduced from 4 to 1 which covers 4 hours over a weekend period (0.1 WTE). Recruitment is ongoing for further GPs (both sessional and salaried), which may improve the current service provision if successful. The risk score has been reduced in July 2023 to reflect the improved rota position.	
1548 - Risk to the Health Board maintaining service provision due to industrial action	09/11/22	Director of Workforce & OD	**3x3=9** (Reviewed 21/06/23)	The Royal College of Nursing (RCN) have confirmed their continued industrial action over June and July 2023. The Society of Radiographers (SoR) are also in consultation with their members. In addition, there has been, and may be further strike action taken within Welsh Ambulance Service NHS Trust (WAST). Mitigation and contingency measures, together with command and control structures put in place have resulted in a co-ordinated response to minimise impact as far as possible. To date no instances of direct patient harm have been recorded.	**2x3=6**

				However, as with previous days of industrial action, a number of patient appointments and surgical slots have had to be re-scheduled impacting on waiting times (however, impact of imminent strike action currently appears less as the appetite to strike seems to be lower within union members). The risk score has been reduced to reflect the current position.	

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 11/07/23)	The service was experiencing significant waiting times as a result of increasing demand levels which are now back to pre-pandemic levels, compounding the backlog due to Covid restrictions. Due to increasing Did Not Attend (DNA) rates (c25%), 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. For Autism Spectrum Disorder (ASD), a meeting took place with the Delivery Unit to establish trajectories, along with the commissioned service which was agreed in March 2023. For psychological	**3x4=12**

				services a trajectory is now in place for 1% per month.	
1559 - Risk of power outages across all clinical and corporate functions of the Health Board due to external influences	01/11/22	Director of Public Health	**3x4=12** (Reviewed 21/06/23)	Risk from power outages has been highlighted at UK level in the National Security and Risk Register and also at regional level in the Dyfed Powys Local Resilience Forum Community Risk Assessment. Welsh Government is working with UK Government on the resilience of the energy system. In line with standard practice, the systems operators for gas and electricity have completed their winter outlooks. Their central scenarios, based on the functioning of normal market conditions, suggest there will be sufficient margins across both gas and electricity. However, there is recognition that we face unprecedented threats to the normal operation of energy markets. The key threat being the impact of supply restrictions of Russian gas to mainland Europe and the impact this has on rest of the world supplies and energy trading arrangements from mainland Europe into the UK. This on top of traditional winter risks (low renewable energy generation, major infrastructure failure and high demand as a result of colder weather) mean there is a reasonable worst-case scenario where emergency measures are enacted. The Health Board has a number of measures in place to respond to such events, however assurance is being sought on wider	**2x4=8**

				impacts which may affect the Health Board's delivery of safe patient care. The current risk score remains due to the intelligence gathered and mitigation measures in place.	
684 - Risk to the timely investment and replacement of Radiology equipment	04/01/19	Director of Operations	**3x4=12** (Reviewed 15/06/23)	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 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 12 reflecting that some equipment has been installed and is operational. 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 June 2023, confirmation on funding was awaited.	**2x4=8**

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.

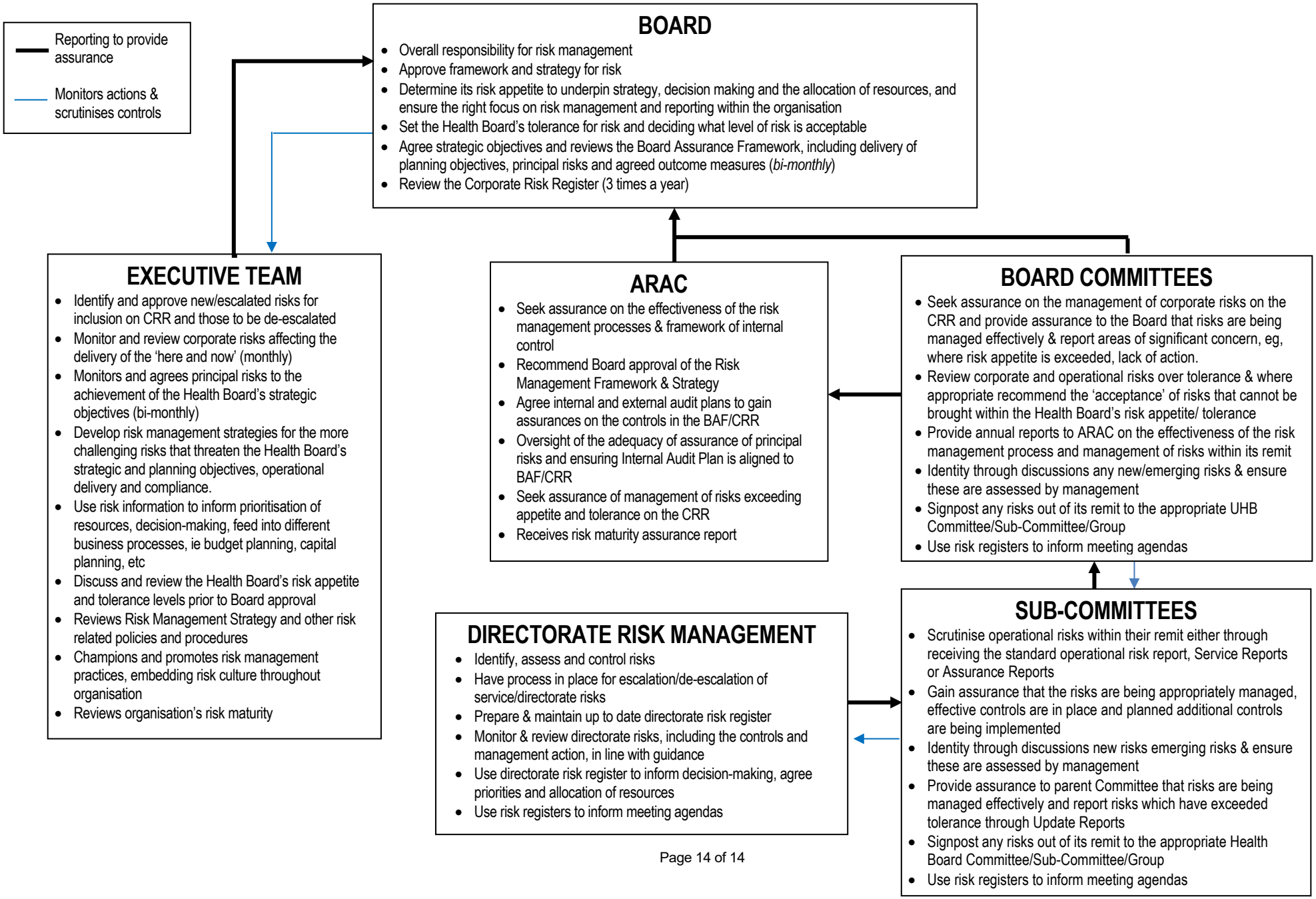
Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.2 Seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance 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: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply 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



Appendix 2

CORPORATE RISK REGISTER SUMMARY JULY 2023

Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Jul-23	Trend	Target Risk Score	Risk on page no...
797	Shortage of staff in sonography affecting the whole Health Board.	Carruthers, Andrew	Safety - Patient, Staff or Public	8	N/A	**5×4=20**	New risk	**3×4=12**	3
1027	Delivery of integrated community and acute unscheduled care services	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×5=25	**4×5=20**	↓	**3×4=12**	7
1032	Risk of not meeting Welsh Government targets for Mental Health and Learning Disabilities (MH&LD) clients	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	**5×4=20**	→	**3×4=12**	12
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	N/A	**4×5=20**	New risk	**2×5=10**	19
129	Risk to the ability to deliver urgent Primary Care OOH Service due to current service model and recruitment difficulties	Carruthers, Andrew	Service/Business interruption/disruption	6	4×4=16	**3×4=12**	↓	**3×3=9 Accepted**	22
684	Risk to the timely investment and replacement of Radiology equipment	Carruthers, Andrew	Service/Business interruption/disruption	6	3×4=12	**3×4=12**	→	**2×4=8**	26
1559	Risk of power outages impact across all clinical and corporate functions of the Health Board	Gjini, Ardiana	Safety - Patient, Staff or Public	6	3×4=12	**3×4=12**	→	**2×4=8**	29
1531	Inability to safely support the Consultant on-call rota at WGH and GGH	Carruthers, Andrew	Safety - Patient, Staff or Public	6	N/A	**2×5=10**	New risk	**5×2=10**	32
1548	Risk to the Health Board maintaining service provision due to industrial action	Gostling, Lisa	Safety - Patient, Staff or Public	6	3×4=12	**3×3=9**	↓	**2×3=6**	35

Assurance Key:

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

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

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

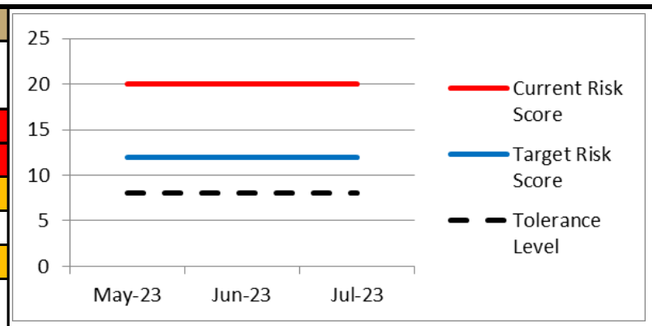
Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective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

Date Risk Identified:	Nov-19
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jul-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Aug-23

Risk ID:	**797**	**Principal Risk Description:**	There is a risk of being unable to provide a full range of ultrasound services including antenatal. This is caused by the retirement and resignation of current sonography staff, low availability of sonographers UK wide, including locum staff 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:	*New risk*



Rationale for CURRENT Risk Score:
Despite best efforts, the service remains fragile and supported by long term agency staff. Vacancies remain unfilled, with the inability to recruit despite repeated recruitment attempts. Long term vacancies exist in Bronglais, Prince Philip and Withybush - in particular in terms of modality lead sonographers at Withybush as at July 2023 - it is noted that a secondment is currently underway at PPH. There are a number of expected retirements and planned maternity absences in the near future. There will also be the inability to secure agency staff from July 2023 in Withybush. As a result of the loss of ultrasound modality leadership in the team at Withybush, this is resulting in reduced ability to undertake governance and audit requirements. A midwife has recently qualified after receiving sonography training at Withybush in April 2023, and a further trainee qualified at Prince Philip, but has since gone on maternity leave. More sonographers are due to be trained from January 2024. However, difficulties remain in obtaining locum staff, exacerbated by registration requirements. As at July 2023, the Radiology directorate have four adverts for differing sonography roles across the Health Board, ranging from leadership in sonography and training, with vacancies open until September 2023.

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.

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. Additional sessions held where possible by a small cohort of non-injured substantive staff to increase obstetric capacity. Urgent escalation at WGH is currently covered by site lead, however this is not sustainable. Ultrasound Control Group now in place, meeting on a fortnightly basis to assess current sonography position across the Health Board, and to develop a short-term and medium-term strategy, both temporary and permanent to encompass and look at current models and staff skill set. Meetings are attended by colleagues from Women and Children, Head of Strategic Workforce Planning, AD of Therapies, Director of Public Health, GM for Radiology, Head of Radiology and site leads.	No long-term modality lead in WGH. 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. Lack of suitable accommodation to attract new staff.	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	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
		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, and if successfully recruited to, will allow for additional training to be undertaken.
		Work with the workforce planning team to build a sustainable workforce plan for ultrasound services.	Roberts-Davies, Gail	31/10/2023	Fortnightly workforce planning meetings in place with colleagues from Radiology and Workforce in attendance.

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	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.
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.
Explore opportunity to creating and recruiting clinical sonography educators post for the Health Board	Lingwood, Gill	31/10/2023	Clinical Educator roles have been developed, with job descriptions being presented to panel in June 2023, with the role being advertised in July 2023. Once clinical educators are in post, any internal vacancies which remain will be advertised externally as training posts for Allied Health professionals.
Explore incentivisation options in terms of being recruit and retain substantive sonographers	Roberts-Davies, Gail	30/09/2023	Ongoing, and consideration to be given in terms of enhanced advertising to include relocation expenses.
To review accommodation options to support the recruitment of locum sonographers.	Roberts-Davies, Gail	30/09/2023	Head of Radiology to meet with Head of Strategic Workforce, Planning and Transformation on 16 June 2023 to explore this option further

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
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								

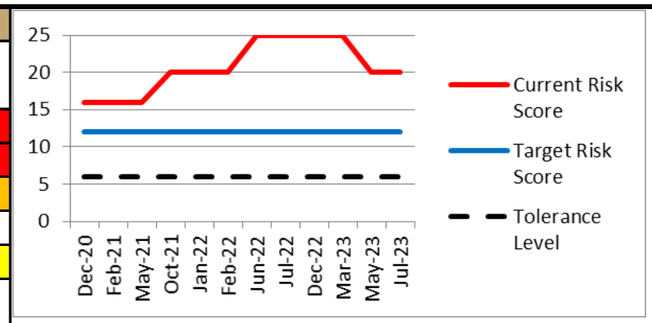
Date Risk Identified:	Nov-20
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	May-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jun-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, 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?	1406, 1548, 1210, 750, 205, 86, 820, 232, 1298, 1281, 906, 1380, 1116, 878, 839, 1167, 1223, 111, 114, 199, 523, 136, 200, 1115, 1078, 572, 1295, 1231, 966, 967, 565, 852, 1295, 1435, 1377, 1083, 180, 1424, 1417, 1309, 291, 118, 925, 119, 1245

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:
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. During recent months, increased levels of COVID-19, Influenza, respiratory disease and norovirus has placed additional pressure on available capacity. 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 has reduced to 20 based on likelihood.

Rationale for TARGET Risk Score:
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.

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 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)	# 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 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,	Create live UEC performance dashboard.	Matthews, Rhian	Completed	UEC live performance dashboard in place.
		Recruitment to UEC Programme Management Office	Matthews, Rhian	Completed	Recruitment process complete.
		Implementation of 111 First and local streaming hub as well as enhancing Same Day Emergency Care (SDEC) provision to reduce conveyance and conversion	Matthews, Rhian	Completed	Fully recruited to existing scheme
		Explore and gain approval for funding for 2wte COTE consultants	Matthews, Rhian	Completed	Completed
		To implement the Standard for Discharge to Assess in accordance with the WG Discharge Guidance	Matthews, Rhian	Completed	Plan to be developed.
		To consider alternative models of medical oversight i.e service level agreement with local GPs and HB salaried community GPs	Matthews, Rhian	Completed	Pending confirmation indemnity for the local GPs to deliver.
		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 BGH
		To codesign schemes with Local Authorities that put urgent capacity into the system to reduce bed occupancy rate for frail, complex patients	Lorton, Elaine	Completed	Work concluded in March 2023, action therefore completed.
		Review extant Escalation Policy to incorporate the whole UEC system	Jones, Keith	Completed	HB Escalation Policy reaffirmed. Sites regularly operating at Red (Level 4) status with limited non-urgent elective surgery undertaken at the four sites due to urgent and emergency care pressures.
		Incorporate and deliver actions that will address control gaps into the Health Board's UEC Plan.	Matthews, Rhian	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.

programme # Supernummery 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).	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 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	Review wider nursing establishment requirements across 25A wards (outside of NSLA) to support increasing capacity and environments for patients.	Passey, Sian	Completed	Complete - All wards have been reviewed and will continually be reviewed, throughout the nurse staffing cycles and through the workforce stabilisation meetings Chaired by workforce, these meeting include each site and consider all wards and services nurse staffing. Additional capacity has been created in Amman Valley. An Alternative Care Unit Y Lolfa became operational in November on the GGH site, with the focus on complex discharges and prevention of further de-conditioning of patients. There are close working relationships with Home First Teams and other based community teams with the purpose of supporting discharge of complex patients into the community at the earliest opportunity. Review of nursing models within EDs will continue through the nurse stabilisation meetings now established.
		To review the West Wales Care Partnership Regional Discharge 2 Assess policy and develop action plan to ensure effective implementation of Policy Goal 5 (optimal hospital care following admission)	Passey, Sian	Completed	Confirmed as complete by Rhian Matthews on 02/12/2022
		Review ambulance handover procedure in conjunction with WAST and HB Review Escalation Policy	Passey, Sian	Completed	The Ambulance Hand over policy which has been updated in collaboration with WAST has now been ratified. An updated self - assessment in relation to recommendations received from HIW has been submitted to WAST in October. Partnership working with WAST and other colleagues continues to address hand over delays and this is being taken forward through TUEC work streams

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 # 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.	Review Escalation Policy	Jones, Keith	Completed	HB Escalataion Policy reaffirmed. Sites regularly operating at Red (Level 4) status with limited non-urgent elective surgery undertaken at the four sites due to urgent and emergency care pressures.
	Review nursing models to support increasing capacity and environments for patients	Passey, Sian	Completed	Continuous discussions with Heads of Nursing and regular operational consideration given to scoping patient profile and pathways. In conjunction with primary care colleagues additional capacity in Amman Valley Hospital.
	Explore service provision in the community for people pending ambulance conveyance, and where conveyance is not possible to manage ambulance handover delays	Matthews, Rhian	Completed	Completed.
	Recruit additional workforce in line with safe staffing requirements for 28 beds in Amman Valley Hospital	Matthews, Rhian	Completed	Completed.
	Development of enhanced Bridging Service and to actively recruit HCSWs to support domiciliary care services	Lorton, Elaine	Completed	Completed.
	To implement the Standard for Discharge to Assess in accordance with the WG 6 Goals Guidance	Matthews, Rhian	~~31/07/2023~~ 31/03/2024	New Welsh Government guidance issued, with phased implementation of the action across financial year 2023/24
	To review findings of local Peer Review and data analysis to inform SDEC model 2023/24	Matthews, Rhian	30/09/2023	Model to be developed
	To review findings of GP Out Of Hours Peer Review, and implement actions as part of planning objective 3A	Matthews, Rhian	30/09/2023	Work is underway
	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	Matthews, Rhian	30/11/2023	Work is underway across the three counties.

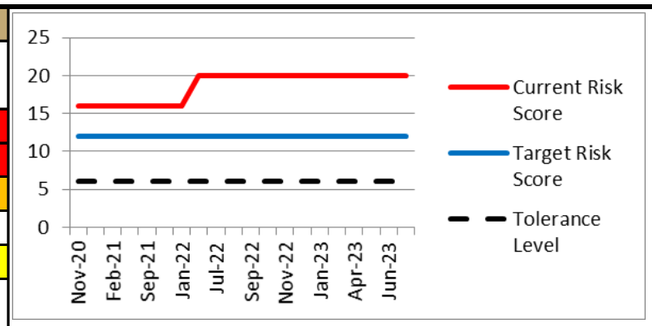
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the 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								

Date Risk Identified:	Nov-20
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jul-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Aug-23

Risk ID:	**1032**	**Principal Risk Description:**	There is a risk of the Health Board not achieving Welsh Government targets in relation to the start of diagnosis of ASD within 26 weeks, and commencement of interventions for Psychological Therapies within 26 weeks. This is caused by an increase in referrals and increasing DNA rates (c25%), as well as recruitment challenges for psychologists. This could lead to an impact/affect on increasing delays in accessing appropriate diagnosis and treatment, delayed prevention of deterioration of conditions and delayed adjustments to educational needs. Additionally, there is potential for adverse publicity, and increased scrutiny/escalation from Welsh Government.
Does this risk link to any Directorate (operational) risks?		138, 1249, 1286, 1287, 1392, 1455, 1422, 1524, 1290, 1260	

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 was experiencing significant waiting times as a result of increasing demand levels which are now back to pre-pandemic levels, compounding the backlog due to Covid restrictions. Due to increasing Did Not Attend (DNA) rates (c25%), 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.
For Autism Spectrum Disorder (ASD), a meeting took place with with the Delivery Unit to establish trajectories, along with the commissioned service which since have been agreed in March 2023. 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.

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 provided for recruitment however national shortage of required skills - 3 new staff have been recruited into the ASD team. Services are in contact with individuals to provide information regarding mainstream/Tier 0 support, wellbeing at home and guidance should their situation deteriorate. Regular meetings with Women and Children's Service to strengthen interdepartmental working. 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. 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 times and control measures. 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 Redesign Group has been established. Trajectories have been identified for Memory Assessment Services and S-CAMHS and there are systems in place to monitor waiting lists at service	Continued lack of IT impacts on staff who have to work from home not having full accessibility. Estates issues ongoing with no access to clinical areas in some localities to see CYP and unable to access GP or LA sites thus restricting clinical sessions. Telephone assessments ongoing, virtual assessment offered but uptake not good for ASD and SCAMHS client group. Reliant on locally held data until reporting available via WPAS team. Currently with Software Development Team since go-live in April 2022.	Directorate is working with the Health Board Performance Team to provide a more detailed report as to the current actions being taken by the Directorate.	Carroll, Mrs Liz	Completed	This work is aligned to the migration of services to WPAS on a priority basis, and complete as at March 2023.
		Explore opportunities for outsourcing for CAMHS ASD and Psychological Therapies.	Carroll, Mrs Liz	Completed	Action included on service level risk register.
		Keeping in touch processes to be in place (Adult Inpatient and Learning Disabilities Services).	Bassett-Gravelle, Ms Lisa	~~30/04/2023~~ 30/08/2023	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

level, through IPAR and Directorate performance meetings. Regular meetings with Estates to look at accessing/leasing/enhancing the current MH estates with a view to increase MH estate footprint. Within the service there is progress in terms of identifying clinical space due to the challenges experienced in accessing additional accommodation outside of the Directorate. Linking with wider Health Board, including corporate teams/Local Authority use of hubs. Works completed in Bro Cerwyn and staff have now returned. Units within the MH&LD footprint have been repurposed. IT are updating infrastructure to enable most efficient use of available space. Service Leads have been tasked with identifying alternative estate options for their areas. 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 Memory Assessment Service, Integrated Autism Service and Adult ADHD. Public facing webpages with QR codes are also being developed to give further guidance and support whilst individuals are waiting. Template letters being developed within further areas. Monitoring of this process will be the responsibility of individual service leads. Service Leads are exploring 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.					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 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.
Repurposing current MH&LD Estate in line with clinical priorities identified.	Carroll, Mrs Liz	Completed	Operational Planning and Delivery Programme Meeting on the 03/05/2023 where it was agreed that the Tudor House Estate would revert back to the Directorate.		

Identify alternative venues/space to hold clinics(CAMHS & Psychological therapies).	Lodwick, Angela	~~31/03/2023~~ 30/09/2023	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.
Identify alternative venues/space to hold clinics (Integrated Psychological Services).	Marshall, Selina	~~31/07/2023~~ 31/07/2023	Rolling programme of groups being developed to enable additional clinical capacity within the service.
Identify alternative venues/space to hold clinics(Commissioning /CDAT).	Richards, Matthew	~~31/03/2023~~ 31/09/2023	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
Directorate to transfer all service data collection processes to WPAS.	Amner, Karen	~~31/03/2023~~ 30/09/2023	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.
Request to be made for additional IT kit to support agile working.	Carroll, Mrs Liz	Completed	Request submitted 23.10.21.
Directorate has funded 12 month fixed term post to accelerate the transition of the entire Directorate on to WPAS with a view to this improving waiting list management and demand and capacity planning. A further two posts have been funded within the Informatics service.	Amner, Karen	Completed	Mapping work continuing MAS, Admiral Nursing, DWBT and Perinatal. Data migration of Integrated Psychological Therapies spreadsheets completed 10.4.22 and service now inputting data at source. for IAS service with the new Service Delivery Manager has now gone live on the 1/11/22 Training sessions continue to be available.
Identify alternative venues/space to hold clinics.	Carroll, Mrs Liz	Completed	These actions have become control measures.

Services will be in contact with individuals to provide information regarding community support, well being at home and guidance should their situation deteriorate.	Carroll, Mrs Liz	Completed	Action assigned to individual service leads.
Funding for Interim Clinical Psychologist lead post to assist with the waiting lists and service development has been identified fixed term for 12 months and will work in conjunction with the new ASD Service Delivery Manager (in post 6 March) to address waiting lists.	Carroll, Mrs Liz	Completed	Interim Clinical Psychologist due to take up post by end of July 2022.
To complete an impact assessment on the recommendations of the Autism Code of Practice.	vaughan, Catherine	Completed	The Regional Partnership Board have commissioned Alder Advice to undertake an audit of our compliance (Health Board/Local Authority/Stakeholders) against the recommendations outlined in the code of practice. We have submitted our developments to date. A regional action plan will be developed based on the outcome of this audit. Implementation plan has been received which members of the Regional Strategy Group are considering. Mapping exercise being undertaken with regard to training needs. Understanding Autism training being rolled out across the Health Board with more specific training for clinicians within the MH&LD Directorate being commissioned.
Review workforce skill mix in light of any potential new funding received from WG for Neurodevelopmental services.	Carroll, Mrs Liz	31/03/2024	As at March 2023, awaiting updates from WG with regards to the release of ND funding
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.

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)	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	~~31/03/2023~~ 30/09/2023	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. Remains ongoing.
	Monthly MH&LD Business Planning and Performance Group overseeing performance	2nd					Outcome measures to be in place to measure effectiveness/quality of services provided (Older Adult Mental Health Services).	Mason, Neil.	~~31/03/2023~~ 31/10/2023	Information reported through Head of Service report to QS&EG. Patient experience feedback process in development in collaboration with corporate team. Admiral Nurse Service is fully compliant. All CMHTs have agreed a standard-set of outcome measures CROMS/PROMS/PREMS for both People Living with Dementia & service users with functional mental ill health problems and their carers, commencing application. MAS have nearly completed. OAMH hosted a Regional Lead post to facilitate directorate wide improvements for PROMS.

MH&LD QSE Group overseeing patient outcomes	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.
Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC	2nd			Outcome measures to be in place to measure effectiveness/quality of services provided(Commissioning /CDAT).	Richards, Matthew	~~31/03/2023~~ 31/09/2023	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.
W-PAS Internal Audit (reasonable assurance(	3rd			There are outcome measure in place within Psychological Therapies following intervention with a plan to develop a Task and Finish group to look at themes and areas which may require further improvement.	Marshall, Selina	Completed	Directorate have been asked to participate in Health Board wide Task & Finish group. The Directorate will raise the importance of Service User/Carer input into this group to ensure the patient experience is represented to inform the outcome. Outcome measures will form part of this project.
An update was requested by the Chair and provided for the August Quality, Safety, Assurance Committee.							

Date Risk Identified:	Jun-23
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jul-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Aug-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 and outpatient services, the inability to achieve ministerial priorities as set out in the Annual Plan 2023/24 (eg, improvements to ambulance response times and emergency department waiting times), and poorer patient outcomes from delays in care. 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	

Risk Rating:(Likelihood x Impact)	**No trend information available.**
Domain:	Service/Business interruption/disruption
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*

Rationale for CURRENT Risk Score:
Inpatient elective surgery as would ordinarily be delivered from Ward 9 on site are currently suspended as of June 2023. Surveys undertaken on Ward 12 have identified urgent remedial work to be undertaken, and the ward as of July 2023 is empty. The Estates and Facilities Directorate are currently undertaking risk assessments on the wards which have yet to be surveyed to determine the impact on staff and patient safety. Based on the current number of planks affected the potential exists for there to be unstable very high-risk planks in areas which continue to be used. Until further survey work is concluded we will be unable to confirm the extent of red or very high-risk planks in those areas which have not yet been surveyed.

Rationale for TARGET Risk Score:
Surveys being undertaken will result in appropriate project plans to be put in place, which once completed will reduce the likelihood of service disruption. There are a high number of "amber" planks which will require continual monitoring over the coming years, with the possibility that they may also deteriorate and require additional remedial work.

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 to decant Ward 12 Comprehensive plan in place to undertake planned surveys - contractor on site Commenced programme of works, Pot Wash area completed and Ward 9 commenced (planned completion end of September) Emergency pathways in place to minimise admissions and length of stay (LOS) in hospital Implementation of different model of care in Cleddau Ward to facilitate improved patient flow Optimising available inpatient capacity, where possible. Utilising Acroprop measures to mitigate the risk while surveys and remedial works continue Internal and External Communications undertaken and planned approach going forward WGH RAAC Control Group, consisting of key estates and service management	Clarity on funding streams required to progress remedial works, which as at June 2023 currently unapproved. To continue with this programme at pace is significantly beyond that which can be supported by our Discretionary Programme Clarity on scope and associated timelines of the required remedial works	To explore funding options with Welsh Government to support remedial work	Davies, Lee	31/07/2023	To be provided at next risk review
		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	As at July 2023, still awaiting clearance from MWWFRS - meeting scheduled 19 July 2023
		Develop a programme of works at WGH to address survey outcomes	Williams, Paul	30/09/2023	Current timescales suggest that remedial works on Ward 9 will be complete by September 2023, however it is noted that further remedial works may take longer dependant on survey outcomes.
		Liaise with affected services and departments to communicate the impact of service disruption on their areas	Cole-Williams, Janice	31/07/2023	Site management to liaise with services to raise awareness of the disruption in relation to corridors and office spaces
		Reviewing service delivery response and developing contingency plans in the event of losing significant capacity	Carruthers, Andrew	30/09/2023	To be updated at next risk review

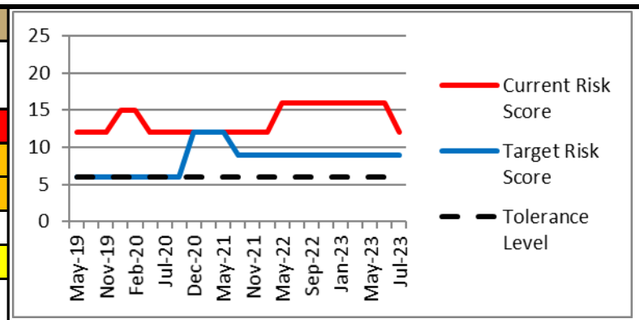
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Project plans in place dependant on outcomes of surveys, and monitored via the WGH RAAC Control Group	RAAC survey findings by external contractor	3rd			RAAC paper to SDODC (Apr 23) RAAC paper to HSC (Jul 2023)	Unaware of the extent and impact of the risk until all surveys have been completed	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
	Fortnightly WGH RAAC Control Group meetings	1st								

Date Risk Identified:	Apr-17
Strategic Objective:	N/A - Operational Risk

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jul-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Aug-23

Risk ID:	**129**	**Principal Risk Description:**	There is a risk of the inability to deliver the statutory requirement of an Urgent Primary Care Out of Hours Service for Hywel Dda patients This is caused by outdated and unsustainable GP dominant workforce model as GPs near retirement age and pay rate differentials (50% reduction over last 5 years) across Health Boards in Wales that impact the UHB's ability to recruit in the mid-long term. This could lead to an impact/affect on a detrimental impact on patient experience, as patients would need to go to an ED/MIU to receive treatment for a primary care complaint to be managed. The inability to provide an out of hours service would also add to day to day GP demand, delayed care for patients and over-reliance on other services such as district nursing and ART teams. The unscheduled care pathway including WAST/primary care could continue to suffer ongoing disruptions due to unmet demand for the OOH service seeking alternative management. This risk may also result in the unforeseen deterioration of an unmanaged condition in a patient, thus becoming more complex to resolve if not dealt with in a timely manner.
Does this risk link to any Directorate (operational) risks?		826, 1352	

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	3×3=9
26/11/2020 - Board 'Accept' Target Risk	
Tolerable Risk:	6
Trend:	⟺



Rationale for CURRENT Risk Score:
Fragility of out of hours (OOH) service delivery continues. Rotas continue to be fragile, particularly at weekends and holiday periods. The inability to recruit GPs, caused primarily by an aging workforce, combined with increased demand for face-to-face, longer complex consultations, and increasing pressures in day-to-day primary care which is impacting the ability of GPs to be available for OOH shifts. In addition, some clinicians may preferentially work in other urgent emergency care initiatives such as 111 First or Same Day Emergency Care (SDEC), as they are potentially much lighter (a pattern reported by Swansea Bay University Health Board (SBU HB) OOH service). This is exacerbated by the minimal numbers of newly qualified GPs applying or enquiring about OOH working patterns. Any further absence on OOH provision is likely to rapidly result in further deterioration of the current position. Availability of daytime work, potentially leading to less availability of locums available for OOH. The Health Board currently has approximately 43 GPs (compared to 100 5 years ago) who regularly work the rotas, and an additional 10-20 who only work bank holidays rotas due to enhanced rates. Advanced Nurse Practitioners (ANP) staff have reduced from 4 to 1 which covers 4 hours over a weekend period (0.1 WTE). Recruitment is ongoing for further GPs (both sessional and salaried), which may improve the current service provision if successful. The risk score has been reduced in July 2023 to reflect the improved position in rota-fill for the service.

Rationale for TARGET Risk Score:
Service rota positions remain variable with continued shortfalls in clinical cover variably affecting service provision. Generally the rotas continue to be unstable, particularly at the weekends and holiday periods, and this is further compounded by the need for salaried staff to take annual leave and sessional staff to have time off to rest. Medium term actions are still required, especially in terms of service modernisation. Work to develop a long term plan for OOH Services has now recommenced following Covid-19 in order to reduce this risk on a permanent basis so to ensure the out of hours service provision is not interrupted. Workforce and service redesign are being considered which will take into account the findings of the recent peer review. There are concerns regarding the future stability of the service, and a need for a greater workforce development plan from central government is really required. TCS must include a more realistic workforce plan to future proof the whole Health Board.

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**
# GP's rotas across the 3 counties are now managed centrally via the administration team based in Haverfordwest and using Rosta master to identify gaps in shifts and cover # Dedicated GP Advice sessions in place at times of high demand (mostly weekends and bank holidays). # Remote working telephone advice clinicians secured where required. # Health Professional feedback form in use between clinicians, service management and 111 (WAST) leads. # WAST Advance Paramedic Practitioner (APP) resource in place. # Rationalisation of overnight bases in place since March 2020, now subject to service review. # Workforce and service redesign requirements flagged as part of IMTP. # Deputy Medical Director meetings on a weekly/bi-weekly basis, helps to ensure governance of the service. # Regular review of risk register with Assurance & Risk Officer. # Agreed pathway for PPH Minor Injury Unit in place. # GP Hub in place where locum sessions can be accessed centrally to support service provision - however there are issues/delays with onboarding in Hywel Dda therefore this has not benefitted Hywel Dda. # Ongoing recruitment activity and workforce planning/design in order to bolster the MDT model and maintaining service stability, and links developed with Primary Care to support this activity. # Use of telephone consultations for service delivery alongside remote working, which has increased by 60% due to the pandemic. # Business Continuity Plans in place to ensure continuity of service, and daily BCI meeting between the National 111 team, WAST and health boards. # Service capacity is measured via a national RAG status # Improvements in the qualitative data and reporting, with support from Primary Care # Regular interaction with regards to industrial action and subsequent planning # January 2023, review of pay structures for sessional GPs, with hourly rates now increased for those shifts considered to be more undesirable. All hourly rates were increased by 5%, with additional variance for the more shifts with higher demands - noted that this is a trial scheme, which is to be reviewed. # Improving Together Sessions in place, where progress and performance of the OOH service reviewed. # Peer Review (June 2022) noted on the Health Board's Audit and Inspection Tracker, and progress against recommendations monitored bi-monthly via Audit and Risk Assurance Committee (ARAC) # Improved use of Dashboard reporting to determine demand and capacity	The ability to influence workforce participation remains limited due to the lack of contractual agreements (reliance on sessional staff). Difficulties in the recruitment and retention of staff. Competing with other services for same staff, eg SDEC. Concerns regarding the future stability of the service and wider impact on other services such as A&E and admissions and daytime services, GP practice and district nursing, and a need for a greater workforce development plan from central government is really required. TCS must include a more realistic workforce plan. Need for formalised workforce plan and redesign is still required - reflected in IMTP submission. Low levels of incident reporting and feedback to improve understanding of quality of service. Peer review identified cultural issues within the service. While PPH MIU Pathway in place, the site are experiencing difficulties with regards to GP cover, affecting the efficiency of this pathway. National RAG status isn't yet mature, doesn't differentiate between the the spectrum of clinical competencies and abilities. The current ADASTRA system contract expires in December 2023, and should there be any delays with the rollout of Salus (replacement system), the service will need to revert to Business Continuity Plans.	Develop a sustainable out of hours service aligned to TCS and the Urgent Emergency Care (UEC) Programme taking into consideration the the findings of the internal service review and the recent Peer Review (when received).	Richards, David	31/10/2023	Peer Review report to be presented at May 2023 OpQSE, with recommendations from the review being worked through. Meetings and discussions ongoing with UEC management. Progress is ongoing and reported through Improving Together sessions.
		Implementation of the recommendations of Out of Hours Peer Review undertaken in Jul22	Richards, David	Completed	Report has been received, to be presented at May 2023 OpQSE, and the recommendations are noted on the UHB Audit Tracker, progress of which is monitored bi-monthly by ARAC.
		Educate GPs on importance of incident reporting to improve the quality of service	Archer, Dr Richard	Completed	Journal club was held 5th April 2023 in order to educate GPs, a result of which has seen a slight increase in the number of incidents being reported. This will be continued to be monitored.
		Develop a streamlined process to onboard GPs from the All Wales GP Hub with workforce colleagues	Archer, Dr Richard	~~31/01/2023~~ 31/05/2023	Improving Together sessions being utilised to identify methods to streamline this process. Peer review findings and management responses were due to be discussed with Welsh Government on 6th March 2023, however this meeting was cancelled. Dates are being circulated to reschedule for mid-April 2023. Peer review and management responses to be presented to OpQSE on 11th May 2023. As at May 2023, GPs are able to onboard within a few weeks, which is an improved position for the Health Board - however it is noted that this is not as streamlined as other Health Boards in Wales.

Continuity Plans.	Work with the workforce relationship team to improve the relationship between management, clinical staff and GPs	Richards, David	~~31/10/2023~~ 31/03/2024	Service Delivery Manager to meet with Workforce to progress further with this action, along with the Deputy Director of Operations and potentially Assistant Director of Primary Care. Findings from the recent Peer Review as at May 2023, along with the Internal Service Review to form basis of future discussions.
	Review leadership roles and recruit to expand both at system and operational level	Richards, David	30/09/2023	Leadership capacity is subject of discussion at Improving Together sessions, however longer term development opportunities may be required.
	Develop escalation plan with clear routes and methods of escalations.	Richards, David	30/09/2023	Existing escalation plans to be reviewed, and to consider intra-shift escalation plans going forward.
	Pilot a model in Carmarthenshire based on the Airedale rural model, which will offer support to the residential care sector	Matthews, Rhian	30/09/2023	This action was raised in the Jun 2022 Peer Review model, and progress tp be provided at future risk review in terms of its implementation.

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
Bi-monthly IPAR. (Monthly updates to IPAR including areas of concern and statistics). National Standards and Quality Indicators- submitted monthly to WG. Issues raised, and performance Matrix reviewed, at National OOH forum (bi-monthly, attended by WG).	Daily demand reports to individuals within the UHB	1st			OOH Paper - QSEC (Oct21)					
	Twice a week sitreps and Weekend briefings for OOH	1st								
	Monitoring of performance against 111 standards	1st								
	Issues raised at fortnightly meeting with Primary Care Deputy Medical Director and Associate Medical Director	1st								
	Monthly report to Joint Operations Group (WAST, 111 team & 111 Health Boards)	2nd								

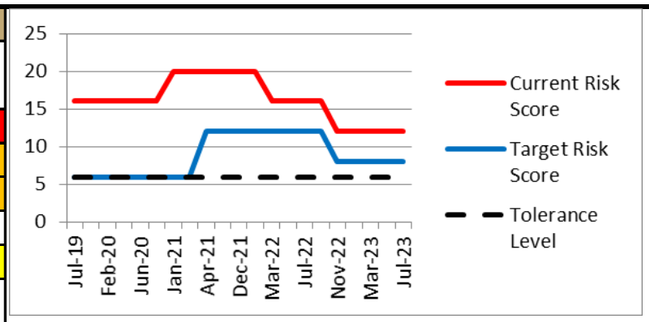
QSEC monitoring	2nd						
Issues raised, and performance Matrix reviewed, at National OOH forum (bi-monthly, attended by WG)	3rd						
WG Peer Review Oct 19	3rd						
Peer Review Jul-22 (final report to be presented to OQSESC in May 2023)	3rd						

Date Risk Identified:	Jan-19
Strategic Objective:	N/A - Operational Risk

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jun-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Aug-23

Risk ID:	**684**	**Principal Risk Description:**	There is a risk to the radiology service provision from breakdown of key radiology imaging equipment (the general rooms and mobile fluroscopy unit in Bronglais). 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):	3×4=12
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 12 reflecting that some equipment has been installed and is operational. 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 June 2023, confirmation on funding was awaited.

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.

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.Some funding has been secured from AWCP for some replacements but does not cover all outdated equipment nor the future requirements. # Escalation process in place for service disruptions/breakdowns. # WG Funding agreed for 2 x CT scanners (GGH & WGH) - now installed # Additional CT secured in the form of a mobile van in December 2020. # 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.	Work with planning colleagues about sourcing capital funding through DCP and AWCP.	Roberts-Davies, Gail	Completed	Two business cases have been funded by WG. Further Business Cases for the further 3 CT scanners and or General Rooms (depending on priority) to be submitted in 2022/23.Submit updated paper to CEIMTSC to outline current priorities and funding requirements from DCP and AWCP. 21/12/2021 - discussion with the Head of Radiology has confirmed that all relevant funding has been sourced, with ongoing work to install equipment / updates to be made alongside the Estates time. Action complete with regards to funding.
		Installation of CT Scanner at Withybush General Hospital	Roberts-Davies, Gail	Completed	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise. As of 25/05/2022 the installation of this equipment is currently running to schedule.
		Installation of scanner at Prince Philip Hospital	Roberts-Davies, Gail	Completed	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise. Installed and operational in October 2022.
		Installation of CT Scanner at Bronglais General Hospital	Roberts-Davies, Gail	Completed	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise.
		Installation of DR room in Prince Philip Hospital	Roberts-Davies, Gail	Completed	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise. Installed and operational in October 2022.
		Installation of DR room in Glangwili General Hospital	Roberts-Davies, Gail	Completed	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise. Installed and operational in November 2022.

Installation of DR room in Withybush General Hospital	Roberts-Davies, Gail	Completed	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise.
Installation of fluoroscopy room in Bronglais General Hospital	Roberts-Davies, Gail	Completed	Completed in April 2023, therefore action closed.
Replacement of Mammography equipment at Prince Philip Hospital	Roberts-Davies, Gail	Completed	Completed in April 2023 therefore action to be closed
To confirm the capital funding to replace existing aged equipment for FY 2023/24	Roberts-Davies, Gail	~~31/03/2023~~ 30/06/2023	A prioritisation list of aged equipment to be replaced has been devised as at November 2022, however confirmation needed on funding in order to undertake the required work. Still awaiting funding outcomes as at June 2023.

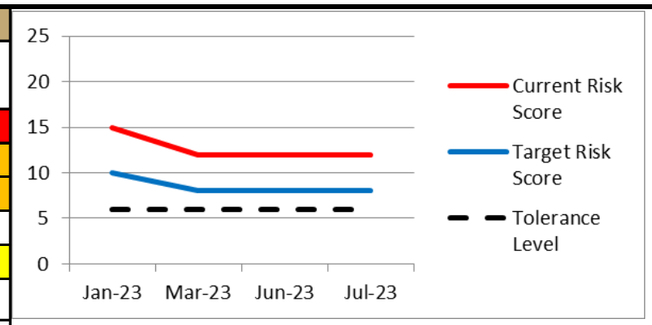
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the 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								

Date Risk Identified:	Nov-22
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Gjini, Ardiana	**Date of Review:**	Jun-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Aug-23

Risk ID:	**1559**	**Principal Risk Description:**	There is a risk of the Health Board being unable to maintain all areas of health board business including routine, urgent and emergency service provision, corporate and administrative functions across health board sites and in our communities/patient's homes in the event of planned and unplanned power outages. This is caused by by supply failure by energy suppliers or severe weather events. This could lead to an impact/affect on patient care, patient safety and delivery of services (including medical devices and equipment). Additionally this could also impact delivery of the Health Boards delivery plan.
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):	3×4=12
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	6
Trend:	



Rationale for CURRENT Risk Score:

Risk from power outages has been highlighted at UK level in the National Security and Risk Register and also at regional level in the Dyfed Powys Local Resilience Forum Community Risk Assessment. Welsh Government is working with UK Government on the resilience of the energy system. In line with standard practice, the systems operators for gas and electricity have completed their winter outlooks. Their central scenarios, based on the functioning of normal market conditions, suggest there will be sufficient margins across both gas and electricity. However, there is recognition that we face unprecedented threats to the normal operation of energy markets. The key threat being the impact of supply restrictions of Russian gas to mainland Europe and the impact this has on rest of the world supplies and energy trading arrangements from mainland Europe into the UK. This on top of traditional winter risks (low renewable energy generation, major infrastructure failure and high demand as a result of colder weather) mean there is a reasonable worst-case scenario where emergency measures are enacted. The Health Board has a number of measures in place to respond to such events, however assurance is being sought on wider impacts which may affect the Health Board's delivery of safe patient care. The current risk score has been reduced due to the intelligence gathered and mitigation measures in place.

Rationale for TARGET Risk Score:

The target score has been reduced as the controls that will be put in place are aimed to reduce the likelihood of impact to patient safety and patient care.

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**
Power Outage Planning Group established. Hospital Sites (all in-patient facilities): Generator provision on inpatient sites (200 hours running time) EFAB bid approved to install plug-in generator connection points on acute hospital sites. Works to be completed by Autumn 2023. Generator maintenance contract with Power Electric. Planned generator maintenance and testing programme in place. Diesel polishing programme underway for bunkered diesel supplies. Acute sites listed on energy provider Protected Supply List (excluding BGH) Rota load disconnection process - all acute sites covered plus AVH and LCH. Primary and Community Care: Out of Hours Service able to operate in all but one base (Llandysul) as located on acute hospital sites. Confirmation of little/no generator provision across primary care. Primary care to manage via their business continuity plans. Local Resilience Forum: Multi agency planning group considering power outage preparedness Regional table top exercise held on 16 Feb 23 (Exercise Lemur) National Tier 1 exercise planned for 28-30 Mar23 (Exercise Mighty Oak) Details of levels of contingency measures within individual care plans in the community determined.	Hospital Sites: Back up generators on inpatient sites - only one per site in place rather than the recommended two per site. Generator connection points to enable portable generators to be connected in times of primary generator failure. Other: Contingency measures for ICT capability and loss of power across health board sites and remote workers for those staff who work from home Community tensions Potential impact on HB premises, eg public accessing sites for power, warmth and communications Development of Communications Strategy Assurances from partner agencies	Strengthening generator provision across all Health Board facilities.	Elliott, Rob	~~31/03/2023~~ 31/10/2023	EFAB bid successful for generator connection points on acute hospital sites with work to be completed by Autumn 2023. Capital bid for additional generators. Bid to be developed for purchase of back-up generator that could be located on any hospital site as needed.
		Clarification on facilities on the Protected Supply List to be sought.	Elliott, Rob	~~31/01/2023~~ ~~30/04/2023~~ 30/09/2023	Challenge on decision to not include BGH on the Protected Supply list submitted to energy provider. Further discussions relating to technical specifications taking place.
		Communications plan to be developed as and when further clarity on potential outages is known.	Hughes-Moakes, Alwena	~~28/02/2023~~ ~~30/04/2023~~ 30/04/2024	Will be developed as and when needed.
		Assurance on levels of contingency measures contained within Social Care (Care Homes and Dom Care packages) to determine any knock-on impact to Health Board.	Paterson, Jill	~~31/01/2023~~ ~~28/02/2023~~ ~~30/04/2023~~ 30/09/2023	Head of Long Term Care progressing.
		Assurance on levels of ICT system resilience and contingencies	Tracey, Anthony	~~31/01/2023~~ ~~30/04/2023~~ 30/09/2023	In progress.
		Power Outage Response Framework to be developed to co-ordinate Health Board response.	Hussell, Sam	30/09/2023	In Progress

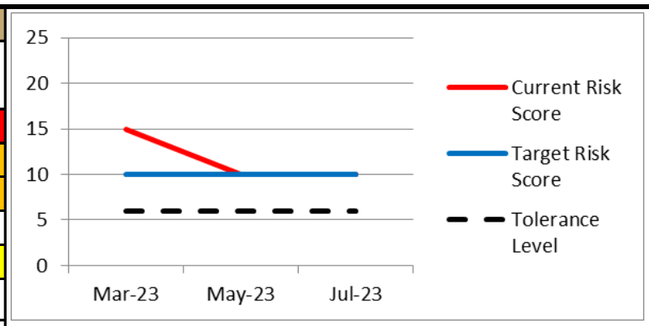
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Power Outage Planning Group established.	1st								
	Regular updates to Executive Team and OPDP.	2nd								
	Dyfed Powys Local Resilience Forum responding to risk.	3rd								
	Dyfed Powys LRF regional Exercise Lemur focusing on power outages held Feb 2023.	3rd								
	National Tier 1 Exercise Mighty Oak focusing on power outages planned for March 2023 - being led by the Cabinet Office and Emergency Planning College.	3rd								

Date Risk Identified:	Nov-22
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jul-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Sep-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):	2×5=10
Target Risk Score (L x I):	5×2=10
Tolerable Risk:	6
Trend:	⟺



Rationale for CURRENT Risk Score:

The current risk score has been reviewed in July 2023, and remains the same to reflect the Board decision in March 2023 to introduce 1 in 3 consultant on-call rota at WGH. There are currently 2 substantive consultants on the rota and 1 locum. Since the introduction of the out of hours pathway there have been limited transfers to date. The new rota is under constant monitoring and review to ascertain and address any issues.

There is continued concern raised regarding the travelling time for a transfer to BGH out of hours.

Rationale for TARGET Risk Score:

The Board approved a proposal to introduce a 1:3 day-time consultant on-call rota from May 2023 which will make the rota safe. From 5pm-9am weekdays and 5pm, Friday to 9am, Monday, consultant on-call will be provided by either BGH or GGH which will reduce the risk to the Target Risk Score, however this will not address the longer term sustainability of the rota. This will prioritised as part of the development of the Clinical Service Plan in 2023/24.

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**
Actively recruiting to two vacant locum consultant posts. Current staff backfill with locum consultants to maintain the rota. Requests with agency for consultant cover. Continuously liaison 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.	Recruitment took place of 2 locum consultants, however, they have both since withdrawn. 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	Completed	The recruitment of 2 locum consultants was successful in May 2023. On week commencing 3rd July, the two locums withdrew. 1 due to not wishing to join the health board and the other candidate had been promoted from a specialty doctor post and would have been £40k worse off, so has made the decision not to progress. Discussions ongoing regarding what the plan will be regarding recruitment, moving forward.
		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.

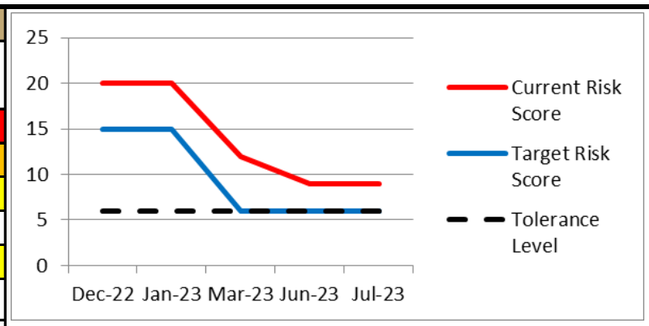
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the 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)	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,									

Date Risk Identified:	Nov-22
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Gostling, Lisa	**Date of Review:**	Jun-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Aug-23

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 WAST. This is caused by a number of unions continuing with 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):	3×3=9
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	6
Trend:	



Rationale for CURRENT Risk Score:
The Royal College of Nursing (RCN) have confirmed their continued industrial action over June and July 2023. The Society of Radiographers (SoR) are also in consultation with their members. In addition, there has been, and may be further strike action taken within Welsh Ambulance Service NHS Trust (WAST). Mitigation and contingency measures, together with command and control structures put in place have resulted in a co-ordinated response to minimise impact as far as possible. To date no instances of direct patient harm have been recorded. However, as with previous days of industrial action, a number of patient appointments and surgical slots have had to be re-scheduled impacting on waiting times (however, impact of imminent strike action currently appears less as the appetite to strike seems to be lower within union members). The risk score has been reduced to reflect the current position.

Rationale for TARGET Risk Score:
The impact has been reduced as the controls that will be put in place, together with staff indications of willingness to work, will reduce the impact to patient safety and patient care. The likelihood score has also been reduced as a result of current negotiations.

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. Scoping of staff groups included in planned action completed. Proactive compilation of critical service areas from a HB perspective (based on Essential Services Guide) completed. Regular scheduled meetings with Trade Unions in place. Regular liaison with RCN Strike Committee established. Process for requesting derogations including on the day requests. Derogation negotiations (exemptions) in place and will be reviewed for each day of action. Arrangements for students in place. 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.	Clarity regarding the intentions of the SoR.	Specific response plans will be developed following notification from specific Trade Unions on dates they intend to take strike action on.	Shakeshaft, Alison	~~05/06/2023~~ 21/08/2023	Will progress as and when strike dates announced.

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 daily	1st								
	Regular updates to Executive Team and OPDP	1st								

RISK SCORING MATRIX

Likelihood x Impact = Risk Score					
Likelihood	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	This will probably never happen/recur (except in very exceptional circumstances).	Do not expect it to happen/recur but it is possible that it may do so.	It might happen or recur occasionally.	It might happen or recur occasionally.	It will undoubtedly happen/recur, possibly frequently.
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least weekly.*	Expected to occur at least daily.*
	* time-framed descriptors of frequency				
Probability - Will it happen or not? (what is the chance the adverse consequence will occur in a given reference period?)	(0-5%*)	(5-25%*)	(25-75%*)	(75-95%*)	(>95%*)
	*used to assign a probability score for risks related to time-limited or one off projects or business objectives.				
Risk Impact Domains	**Negligible - 1**	**Minor - 2**	**Moderate - 3**	**Major - 4**	**Catastrophic - 5**
Safety of Patients, Staff or Public	Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention.	Moderate injury requiring professional intervention.	Major injury leading to long-term incapacity/disability.	Incident leading to death.
	No time off work.	Requiring time off work for >3 days	Requiring time off work for 4-14 days.	Requiring time off work for >14 days.	Multiple permanent injuries or irreversible health effects.
		Increase in length of hospital stay by 1-3 days.	Increase in length of hospital stay by 4-15 days.	Increase in length of hospital stay by >15 days.	An event which impacts on a large number of patients.
			Agency reportable incident.	Mismanagement of patient care with long-term effects.	
			An event which impacts on a small number of patients.		
Quality, Complaints or Audit	Peripheral element of treatment or service suboptimal.	Overall treatment or service suboptimal.	Treatment or service has significantly reduced effectiveness.	Non-compliance with national standards with significant risk to patients if unresolved.	Totally unacceptable level or quality of treatment/service.
	Informal complaint/inquiry.	Formal complaint.	Formal complaint -	Multiple complaints/ independent review.	Gross failure of patient safety if findings not acted on.
		Local resolution.	Escalation.	Low achievement of performance/delivery requirements.	Inquest/ombudsman inquiry.
		Single failure to meet internal standards.	Repeated failure to meet internal standards.	Critical report.	Gross failure to meet national standards/performance requirements.
		Minor implications for patient safety if unresolved.	Major patient safety implications if findings are not acted on.		
		Reduced performance if unresolved.			
Workforce & OD	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff.	Uncertain delivery of key objective/service due to lack of staff.	Non-delivery of key objective/service due to lack of staff.
			Unsafe staffing level or competence (>1 day).	Unsafe staffing level or competence (>5 days).	Ongoing unsafe staffing levels or competence.
			Low staff morale.	Loss of key staff.	Loss of several key staff.
			Poor staff attendance for mandatory/key training.	Very low staff morale. No staff attending mandatory/ key training.	No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
		Reduced performance levels if unresolved.	Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty.	Prosecution.
				Improvement notices.	Complete systems change required.
				Low achievement of performance/delivery requirements.	Low achievement of performance/delivery requirements.
				Critical report.	Severely critical report.

Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage
					Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.
Health Inequalities/ Equity	Minimal or no impact on our attempts to reduce health inequalities/improve health equity	Minor impact on our attempts to reduce health inequalities or lack of clarity on the impact we are having on health equity	Moderate impact on our attempts to reduce health inequalities or lack of sufficient information that would demonstrate that we are not widening the gap. Indications that we are having no positive impact on health improvement or health equity	Major impact on our attempts to reduce health inequalities. Validated data suggesting we are not improving the health of the most disadvantaged in our population whilst clearly supporting the least disadvantaged. Validated data suggesting we are having no impact on health improvement or health equity.	Validated data clearly demonstrating a disproportionate widening of health inequalities or a negative impact on health improvement and/or health equity

RISK MATRIX

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

RISK ASSESSMENT - FREQUENCY OF REVIEW

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