Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ADNODDAU CYNALIADWY
SUSTAINABLE RESOURCES COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 August 2023
TEITL YR ADRODDIAD: TITLE OF REPORT:	Corporate Risk Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Director of Finance Andrew Carruthers, Director of Operations
SWYDDOG ADRODD: REPORTING OFFICER:	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

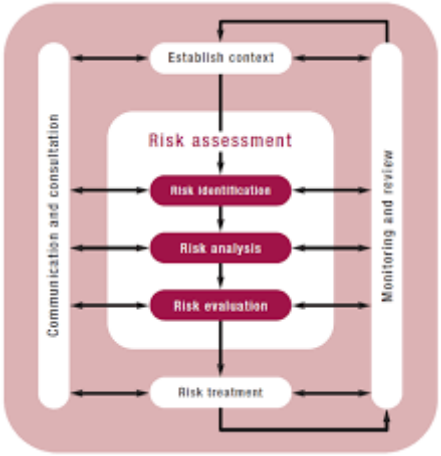
ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Sustainable Resources Committee is asked to request assurance from the identified Executive Director that the corporate risks in the attached report at Appendix 1, are being managed effectively.

Cefndir / Background

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



(Risk Management Process, ISO 31000)

The Board's Committees are responsible for the monitoring and scrutiny of corporate-level risks within their remit. As such, they are responsible for:

- Seeking assurance on the management of corporate risks included in the Corporate Risk Register (CRR) and providing assurance to the Board that risks are being

managed effectively, reporting areas of significant concern - for example, where risk appetite is exceeded, lack of action etc;
- Reviewing operational risks over tolerance and, where appropriate, recommending the 'acceptance' of risks that cannot be brought within Hywel Dda University Health Board's (HDdUHB's) risk appetite/ tolerance to the Board through the Committee Update Report;
- Identifying through discussions any new/ emerging risks, and ensuring these are assessed by management;
- Signposting any risks outside their remit to the appropriate HDdUHB Committee;
- Using risk registers to inform meeting agendas.

The Executive Team has agreed the content of the CRR. These risks have been identified via a top-down and bottom-up approach.

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

The Board has delegated a proportion of its role in scrutinising assurances to its Committees in order to make the most appropriate and efficient use of expertise. Therefore, Committees should also ensure that assurance reports relating to principal risks are received and scrutinised, and an assessment made as to the level of assurance they provide. The reports should consider the validity and reliability of each assurance in terms of source, timeliness and methodology. Robust scrutiny by its Committees will enable the Board to place greater reliance on assurances and will provide the Board with greater confidence in the likelihood of achieving strategic objectives, in addition to ensuring a sound basis for decision-making. It is the role of Committees to provide challenge where missing or inadequate assurances are identified and to escalate any gaps in assurance to the Board (Appendix 1).

Asesiad / Assessment

The Sustainable Resources Committee Terms of Reference state that it will:

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

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

2.9 Receive assurance through Sub-Committee Update Reports and other management/task & finish group reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate).

There are 3 risks assigned to the Committee from the 20 risks currently identified on the CRR.

The 3 corporate 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. Due to the sensitive nature of risk '1352 – Risk of business disruption and delays in patient care due to a cyber-attack', the detail

is being reported to in-committee to provide discussion and assurance. Details on the 2 remaining corporate risks assigned to SRC are included in Appendix 1.

Changes Since Previous Report

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

Note 1 - Increase in risk score

Since the previous report, there has been an increase in risk score for the following risk:

Risk Reference & Title	Date risk identified	Lead Director	Previous risk score	Current risk score	Update	Target Risk Score
1642 - Risk of Health Board not meeting statutory requirement to break even 23/24 due to significant deficit position	13/04/23	Director of Finance	**5x4=20**	**5x5=25** (Reviewed 16/06/23)	The draft Annual Plan for 2023/24 of £112.9m is unacceptable to Welsh Government (WG) and has led to a further deterioration in an already unsupportable underlying deficit position which will impact future years. The Board have been involved in the discussions and decisions in the development of the 2023/24 Plan both through our Committees of the Board, Board Seminar sessions, and Public Board meetings. As a consequence of these on-going discussions and decisions, the Board, at its meeting on the 30 March 2023, approved the	**3x4=12**

					annual plan for 2023/24, recognising the forecast financial outturn remains unacceptable and in breach of the Health Board's statutory requirement to achieve financial balance; further work will be required during 2023/24 to improve the position. At the Board meeting on the 30 March 2023 it was also noted that without further support, at this stage, the Health Board will require further cash-backed support from WG as the extent of our cash allocation will be insufficient to continue to service our liabilities as they fall due after early February 2024. The Health Board was placed in WG's Targeted Intervention level of escalation on 29 September 2022, partly relating to our financial position; the 2023/24 Plan presents a deterioration in both the in-year and underlying financial position since 2022/23.	

					Through our 2023/24 planning process, operational plans to address the financial savings gap and operational variation have not provided sufficient assurance to mitigate the current financial trajectory. If financial support is unavailable from WG, which is a risk given the National financial position, then this could affect patient services and our key stakeholders.	

Note 3 - No change in risk score

Since the previous report, there have been no changes in the risk scores of the following 2 risks:

Risk Reference & Title	Date risk identified	Lead Director	Current risk score	Update	Target Risk Score
1352 - Risk of business disruption and delays in patient care due to a cyber attack	27/01/22	Director of Finance	**4x4=16** (Reviewed 19/07/23)	Detail provided to SRC In-Committee.	**4x3=12**
1335 - Risk to the ability to access paper patient records in a timely manner due to existing records management infrastructure	05/10/21	Director of Operations	**3x3=9** (Reviewed 29/06/23)	Currently across the Health Board there is a considerable variance in both practice and process, operationally when utilising and dealing with the various types of records in use throughout directorates, services and departments. The current records management methodology, results in a non-standardised approach to delivering effective records	**2x3=6**

				management arrangements. With a lack of agreed criteria in terms of managing the record during its life cycle from creation, during retention and to disposable. There is a requirement for an investment in a modern day solution and an alteration to culture and attitude that will embrace change and technology associated with a digital health record (DHR), to manage the risk. The Health Board has selected its electronic document management system (EDMS) supplier, and work has commenced on scanning legacy documents into a development environment.	

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

HYWEL DDA RISK HEAT MAP

	LIKELIHOOD →				
IMPACT ↓	**RARE 1**	**UNLIKELY 2**	**POSSIBLE 3**	**LIKELY 4**	**ALMOST CERTAIN 5**
CATASTROPHIC 5					1642 (↑)
MAJOR 4				1352 (→)	
MODERATE 3			1335 (→)		
MINOR 2					
NEGLIGIBLE 1					

Argymhelliad / Recommendation

SRC is requested to:

- Seek assurance that all identified controls are in place and working effectively;

- Seek assurance that 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.

Subsequently, this will enable the Committee to provide the necessary onward assurance to the Board, through its Committee Update Report, that the Health Board is managing these risks effectively.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.7 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.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Contained within the report
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: **Further Information:**

Ar sail tystiolaeth: Evidence Base:	Underpinning risk on the Datix Risk Module from across HDdUHB's services reviewed by risk leads/ owners
Rhestr Termau: Glossary of Terms:	Explanation of terms is included in the main body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Not Applicable

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 from report, however, impacts of each risk are outlined in risk description.
Cydraddoldeb: **Equality:**	Has EqIA screening been undertaken? No Has a full EqIA been undertaken? No

Appendix 1

SRC CORPORATE RISK REGISTER SUMMARY AUGUST 2023

Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Aug-23	Trend	Target Risk Score	Risk on page no...
1642	Risk of Health Board not meeting statutory requirement to break even 23/24 due to significant deficit position	Thomas, Huw	Finance inc. claims	6	5x4=20	**5x5=25**	↑	**3x4=12**	3
1352	Risk of business disruption and delays in patient care due to a cyber attack	Thomas, Huw	Statutory duty/inspections	8	4x4=16	**4x4=16**	→	**3x4=12**	N/A
1335	Risk to the ability to access paper patient records in a timely manner due to existing records management infrastructure	Carruthers, Andrew	Quality/Complaints/Audit	8	3x3=9	**3x3=9**	→	**2x3=6**	8

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

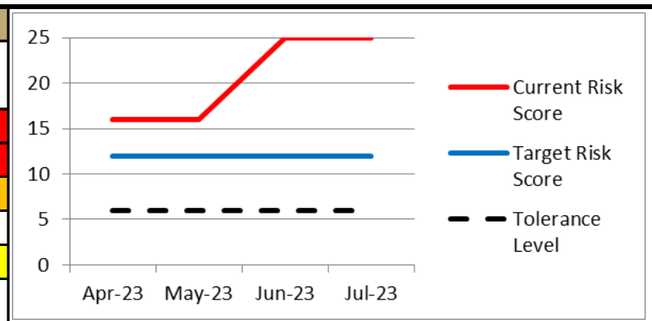
Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective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

Date Risk Identified:	Apr-23
Strategic Objective:	

Executive Director Owner:	Thomas, Huw	**Date of Review:**	Jun-23
Lead Committee:	Sustainable Resources Committee	**Date of Next Review:**	Jul-23

Risk ID:	**1642**	**Principal Risk Description:**	There is a risk that the Health Board deficit is unaffordable for Welsh Government This is caused by the Financial Plan for 2023/24 presenting a significant deficit position, which reflects the significant step-change in expenditure during COVID-19. This has persisted, as operational pressures have remained; and a further step-change in expenditure is expected into next year, arising, largely, from inflationary pressures. Additional causes include: 1. Insufficient assurance over the identification or operational delivery of the required level of savings in the year because of continued operational and clinical challenges across our services, in particular within urgent and emergency care; 2. Further in-year operational cost deterioration either due to operational decisions or market price volatility within areas such as Prescribing and Energy. This could lead to an impact/affect on the sustainability of the Health Board's financial position, with a cash funding shortfall and the ability to meet payments as and when they fall due from Q4 2023/24.There will also be an impact on the ability to meet Ministerial priorities of breaking even, along with the ability to maintain patient services.
Does this risk link to any Directorate (operational) risks?			980, 968, 964, 966, 975, 983, 971, 965, 1644, 1646

Risk Rating:(Likelihood x Impact)	
Domain:	Finance inc. claims
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	5×5=25
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6
Trend:	



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
The draft Annual Plan for 2023/24 of £112.9m is unacceptable to WG and has led to a further deterioration in an already unsupportable underlying deficit position which will impact future years. The Board have been involved in the discussions and decisions in the development of the 2023/24 Plan both through our Committees of the Board, Board Seminar sessions, and Public Board meetings. As a consequence of these on-going discussions and decisions, the Board, at its meeting on the 30th March 2023, approved the annual plan for 2023/24, recognising the forecast financial outturn remains unacceptable and in breach of the Health Board's statutory requirement to achieve financial balance; further work will be required during 2023/24 to improve the position. At the Board meeting on the 30th March 2023 it was also noted that without further support, at this stage, the Health Board will require further cash-backed support from Welsh Government as the extent of our cash allocation will be insufficient to continue to service our liabilities as they fall due after early February 2024. The Health Board was placed in WG's Targeted Intervention level of escalation on 29 September 2022, partly relating to our financial position; the 2023/24 Plan presents a deterioration in both the in-year and underlying financial position since 2022/23. Through our 2023/24 planning process, operational plans to address the financial savings gap and operational variation have not provided sufficient assurance to mitigate the current financial trajectory. Without further support, at this stage, the Health Board will require further cash-backed support from Welsh Government as the extent of our cash allocation will be insufficient to continue to service our liabilities as they fall due after early February 2024. If this support is unavailable, which is a risk given the National financial position, then this could affect patient services and our key stakeholders.	The Health Board needs to demonstrate that it is able to manage its financial position effectively, cognisant of the risks which are inherent in the delivery of safe and timely care. The current draft Financial Plan does not provide sufficient assurance of this and urgent management actions are required to address this. Given the challenge in delivering an acceptable financial position this year, it is unlikely that the Health Board will achieve a risk which is in line with the existing tolerable risk of 8 for the year. Consequently, it has been requested of the Board to increase the tolerable risk score to 12 in line with the Target.

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**
1. Modelling of anticipated patient flows, and the resultant workforce, equipment and operational requirements is managed through operational teams. 2. Financial modelling and forecasting is co-ordinated on a regular basis. 3. Timely financial reporting to Directorates, Sustainable Resources Committee, Board and Welsh Government on local costs incurred as a result of Operational Drivers to inform central and local scrutiny, feedback and decision-making. 4. Oversight arrangements in place at Board level and through the Executive Team structure. 5. Exploration of a number of funding streams, including: Local Health Board funding arrangements; Funding arrangements through the Regional Partnership Board and Local Authority partners. Funding from WG's own sources or from HM Treasury via WG. 6. Opportunities Framework refreshed with the expectation that identified areas of waste will present deliverable cost reductions/formal savings schemes. Linked to Planning Objectives workplan, which will be shaped by the Health Board's strategy, “A Healthier Mid and West Wales", and align to the design assumptions set out in that. 7. Accountability statements in relation to the Opening Directorate Budgets underpinning the draft interim Financial Plan for 2023/24 will issued to the Executive Team in May 2023. The letters clarify that it is	The costs of addressing the Health Board's local needs may exceed available revenue and cash funding. The organisation may fail to deliver the required level of transformational change during the year through which the opening cost base is expected to be rationalised. This is in relation to the continuation of core and other services, the direct (programme) response to COVID-19, specific exceptional costs and the delivery of Recovery and Sustainability Plans.	Targeted Intervention working group and escalation Steering Group to discuss, agree and implement corrective actions to respond to Targeted Intervention status.	Moore, Steve	~~30/06/2023~~ 31/08/2023	Through the approval of the Annual Plan the Board has accepted the validity of the current operational drivers and accepted the choices and identified opportunities available to mitigate the current trajectory. The process is in place, however the cycles are yet to identify corrective actions leading to an in-year or future year financial improvement. As these corrective actions are identified, these will be added to the risk Action Plan. A meeting was held with WG week the week of 19th June 2023 where final deadlines and actions were agreed.

expected that all budget holders manage their services within their allocated budgetary envelope; that it is incumbent on all to ensure that expenditure represents best value; and, that there is the expectation that these operational needs can be clearly demonstrated and that additional costs will reduce as and when decisions are made. 8. Performance against Plan monitored through Improving Together Meetings with Services, including Performance, Quality and Financial information. 9. Implementation of systems for efficiency (Malinko, WellSky, Nurse Documentation system) are driving financial systems for control (Symbiotics, Caf M in Facilities and Estates, Allocate), alongside the Digital Strategy improving grip and control. 10. Weekly financial reporting to Executive Team, tracking week-on-week progress against key metrics. 11. Tactical TI Group meets on a fortnightly basis, led by the Director of Finance as SRO. This reports into an escalation Steering Group, which meets on a monthly basis, chaired by the CEO where specific executive leads meet to discuss, agree and implement corrective actions to respond to the escalated Targeted Intervention status that Welsh Government placed the Health Board during October 2022. The weekly Executive Team meeting chaired by the CEO will be the internal group that monitors and drives progress, focusing on: a) delivery of our Planning Objectives and the subsequent financial benefits; b) efficiency and productivity opportunities (based on our Opportunities Framework); c) corrective actions identified through our regular Executive-led Directorate Use of Resources meetings to reduce current expenditure trajectories.	Develop a revised roadmap to financial sustainability based on the Board's agreed key priorities and revised Planning Objectives in line with our Strategy.	Thomas, Huw	~~30/06/2023~~ 31/08/2023	June-23 - A focused Executive Team Away Day in June considered mitigating actions and their delivery; a six week action timetable has commenced. This is the first step towards developing a roadmap and will link to the clinical services plan.

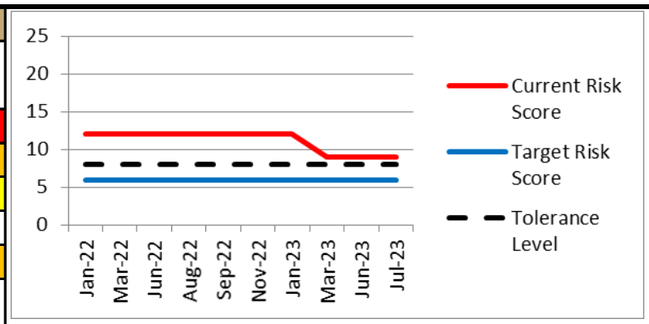
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance against operational plans and targets through Performance KPIs In-month financial monitoring	Performance against plan monitored through Improving Together Meetings.	1st			* Mth 1 Finance Report Board, May 2023 * Mth 2 Finance Report Sustainable Resources Committee June 2023 * Mth 3 Finance Report Going to Board July 2023	None				
	Sustainable Resources Committee oversight of current performance	2nd								
	Transformation & Financial Report to Board & SRC	2nd								
	WG scrutiny through monthly monitoring returns	3rd								
	WG scrutiny through revised monthly Monitoring Returns (specific supplementary templates) and through Finance Delivery Unit	3rd								
	Audit Wales Structured Assessment process	3rd								

Date Risk Identified:	Oct-21
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jun-23
Lead Committee:	Sustainable Resources Committee	**Date of Next Review:**	Aug-23

Risk ID:	**1335**	**Principal Risk Description:**	There is a risk of clinical services being unable to access paper patient records, at the correct time and place in order to make the right clinical decisions and provide effective patient care. This is caused by not having a fit for purpose records management infrastructure along with organisational management arrangements which are insufficient in capacity and scope. This could lead to an impact/affect on the interruption to clinical services, ability to provide effective patient care including compliance with and attainment of nationally agreed Cancer, RTT and Stroke targets, review and fine by the ICO (<£17.5m - £35m fine per episode), increased litigation and negligence claims, complaints and possible redress, non-compliance with GDPR in regards access to patient information, underutilisation of clinical staff, outpatient facilities and day case areas and theatres, inappropriate disclosure of confidential information, missing patient information and confidential documentation, and non-compliance with nationally agreed retention timescales.
Does this risk link to any Directorate (operational) risks?		1434, 1427, 1369, 939,1247, 1419,1445,1627, 708, 1282, 1627	

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	3×3=9
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	8
Trend:	



Rationale for CURRENT Risk Score:
Currently across the Health Board there is a considerable variance in both practice and process, operationally when utilising and dealing with the various types of records in use throughout directorates, services and departments. The current records management methodology, results in a non-standardised approach to delivering effective records management arrangements. With a lack of agreed criteria in terms of managing the record during its life cycle from creation, during retention and to disposable. There is a requirement for an investment in a modern day solution and an alteration to culture and attitude that will embrace change and technology associated with a digital health record (DHR), to manage the risk. The Health Board has selected its electronic document management system (EDMS) supplier, and work has commenced on scanning legacy documents in to a development environment.

Rationale for TARGET Risk Score:
The implementation of a full DHR will support and resolve a number of issues currently being experienced across the Health Board. Prior to making a record digital all services and identified IAO's will have to undertake a full review of their records management arrangements and work in conjunction with a robust criteria to ensure processes follow a standardised approach. A DHR resolves any issues we may currently be experiencing with regards the lack of storage capacity, provision of records in line with GDPR requirements, the ability to facilitate additional clinical requests, the transition to a virtual world, cost benefits, as well as many others. To assist implementation a requirement for adaptation to working practice and a considerable change in culture for future success.

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**
Health Board Information Asset Register Identified Information Asset Owners (IAOs) Health Records Policies, Procedures and SOPs Some digitalisation projects commenced, eg, physiotherapy, A&E cards Health Board e-nursing documentation implementation Planning Objective 5M aligned to SDODC for reporting Electronic systems including: WPAS (Welsh Patient Administration System), WCP (Welsh Clinical Portal), PACS (Radiology), LIMS (Pathology), WAP e-referrals (Welsh Admin Portal), CANIS (Cancer), Diabetes 3, Selma Acquired additional storage facilities to both accommodate excess paper records and establishing a scanning bureau Acquisition of a electronic document management system (EDMS). Lease of a second storage facility Scanning of 308,000 non active patient records DPIAs undertaken on the three contractors for scanning providers, with an additional DPIA being undertaken in June 2023 in relation to RICOH Local Project Steering Group, which meets fortnightly and chaired by Deputy Director of Operations and attended by the Digital Director Programme risk register reviewed at Local Project Steering Group Cataloguing exercise undertaken for the sub-contractor with RICOH	In its paper form, the health record is not under the accountability of any one Executive and hence the degree of influence is potentially compromised. Reduced understanding or records types (across various services) and those appropriate for scanning, long term storage or destruction, leading to a non-consistent criteria for records management during the records life cycle from creation, to retention and ultimate destruction. With the requirement to implement and standardise health records protocols across all services.	Develop and implement scanned health record solution over the next 12 years depending on the split between determination of scanning and deep storage (DHR).	Carruthers, Andrew	31/03/2033	Ã‚£300k per annum for three years made available to prime the project to include acquiring premises to facilitate a scanning bureau along with appointment of a project manager. A paper outlining the direction of travel and key steps to be taken was presented to executive team 28 July 2021 and this was broadly supported. A project implementation plan along with specification for acquiring scanners is being progressed.
		Review current records management arrangements for records that are not within the scope and responsibility of the Central Health Records function. This will require agreement on future record management arrangements, required resources and project support going forward as an essential precursor to the delivering the scanning phase of the project plan. This will be largely driven by individual information asset owners providing comprehensive schedules of information assets under their responsibility.	Carruthers, Andrew	Completed	SBAR submitted to Executive Team in October 2022 outlining the plan for future records management arrangements. Further discussions are now required to fully implement the transition and move records to one centralised locality.
		Director of Operations to meet with Executive Leads with professional responsibility for clinical records to determine agreement on future record management arrangements, required resources and project support. This will be largely driven by individual information asset owners providing comprehensive schedules of information assets under their responsibility.	Carruthers, Andrew	~~31/03/2023~~ 30/09/2023	Meeting to be arranged.

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
	Information Asset Owner Registers Group	1st			Records Storage SBAR - Executive Team (Jul21)					
	Digital Health Records Project Group to oversee delivery of enabling work	2nd								
	SDODC overseeing delivery of Planning Objective 5M	2nd								
	IA Records Management Report (limited - follow up (reasonable) in Health Records only	3rd								

RISK SCORING MATRIX

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

Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage
					Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.
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.