Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 November 2021
TEITL YR ADRODDIAD: TITLE OF REPORT:	Corporate Risk Register
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Steve Moore, Chief Executive
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Wilson, Board Secretary Charlotte Beare, Head of Risk and Assurance

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

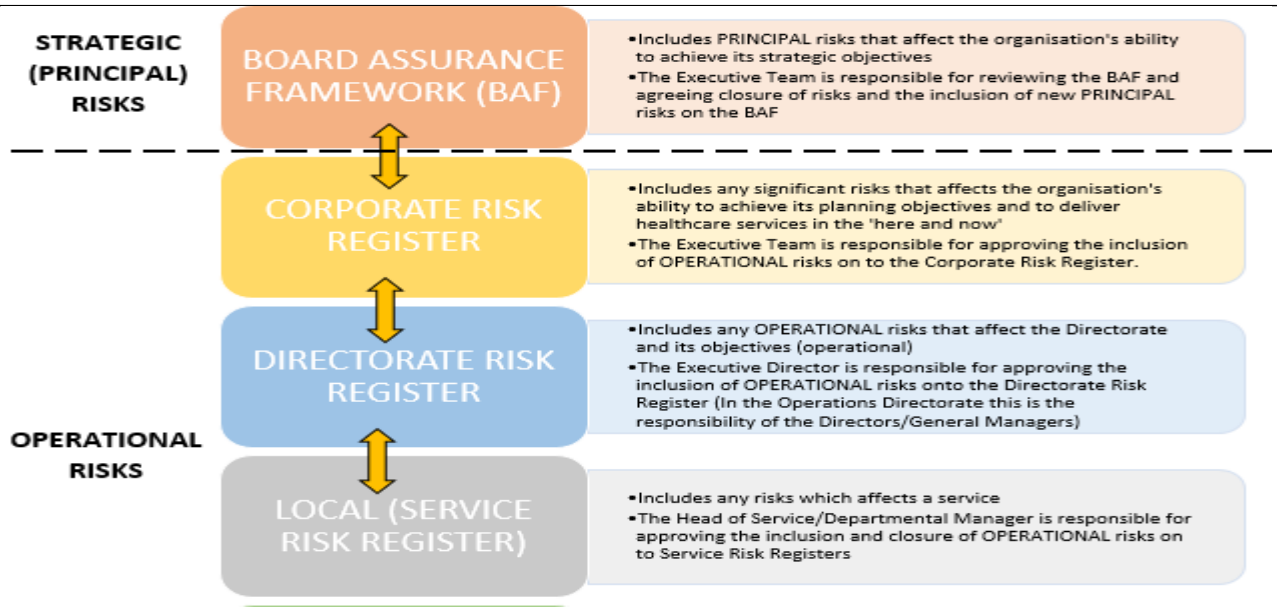
The Corporate Risk Register (CRR) is presented to the Board to advise of the corporate risks of Hywel Dda University Health Board (HDdUHB) and provide assurance that these risks are being assessed, reviewed and managed appropriately/effectively.

Cefndir / Background

Risk management is a key component of the governance framework, and should underpin organisational strategy, decision-making and the allocation of resources; as such the organisation is required to have effective risk management arrangements in place. The Board should receive sufficient and timely assurance information on the management of risk to enable it to exercise good oversight.

The Executive Directors, through the monthly Executive Risk Meeting, are responsible for reviewing and discussing their corporate risks, and agreeing any new risks and the escalation/de-escalation of operational risks that are on directorate risk registers. It is the role of the Executive Directors to review controls and ensure appropriate action plans are in place, which might include the development of corporate risk management strategies to manage risk(s). Effective management of these risks enables the organisation to improve its chances of success and reduce the likelihood of failure.

The CRR includes significant risks that affect the organisation's ability to deliver healthcare in the 'here and now' and its ability to achieve its planning objectives (linked to directorate objectives). This is how the Corporate Risk Register interacts with the principal risks on the Board Assurance Framework and the operational risks that are on Directorate and Service risk registers.



Asesiad / Assessment

Since the CRR was previously presented to the Board in July 2021, the risks have been discussed in detail at its Board Committees, and reported to the Board via the Committee Update Reports. Where assurance has not been received that principal risks are being managed effectively, the Committees can request a more in-depth report at a subsequent meeting. Recent examples of this have taken place at the Quality, Safety and Experience Committee where a deep dive was undertaken into risk 633 (single cancer pathway), risk 129 (out of hours) and 1032 (mental health and learning disabilities waiting times). The risks have also been reviewed on a monthly basis at the Executive Risk meetings.

The CRR includes significant risks associated with delivering the 'here and now', whilst the BAF will identify the Health Board's principal risks to achieving its strategic objectives, and these will be long term in nature. The refreshed Board Assurance Framework (BAF) dashboard was reported to Board in September 2021 and will be reported to every Board meeting going forward.

The following changes have taken place since the CRR was previously presented to the Board in July 2021.

Total Number of Risks	12	
New risks	2	*See note 1*
De-escalated/Closed	11	*See note 2*
Increase in risk score ↑	2	*See note 3*
Reduction in risk score ↓	0	
No change in risk score →	8	

Attached to this report to provide the Board with assurance on the management of its principal risks are:

Appendix 1 - CRR Summary
Appendix 2 - Each risk detailing the strategic objective, controls, assurances, performance indicators and action plans to address any gaps in controls and assurances.

The 12 corporate risks are detailed on the below heat map:

HYWEL DDA RISK HEAT MAP					
	LIKELIHOOD →				
IMPACT ↓	RARE 1	UNLIKELY 2	POSSIBLE 3	LIKELY 4	ALMOST CERTAIN 5
CATASTROPHIC 5		1016	813	117	
MAJOR 4			633 451	1027 1032 1048	684 1027 (↑) 1048 (↑)
MODERATE 3				129	
MINOR 2					
NEGLIGIBLE 1					

Note 1 – New Risks

Since the previous report in July 2021, 2 new risks have been added to the CRR:

Risk	Lead Director	New/ Escalated	Date	Reason
Risk 1218 - Significant pressures expected from RSV and other respiratory viruses on Paediatric Services	Director of Operations	Escalated from Directorate level	06/10/21	This risk was escalated from the Women and Children's Directorate Risk Register to reflect concerns in respect of increasing RSV case-presentations requiring enhanced levels of care, and its impact to the delivery of other essential and routine services. This risk has been recently been expanded to include other respiratory viruses. There is a plan to systematically redeploy staff during times of surge however this will have a wider impact to the delivery of other essential services. The Cilgerran ward environment will be improved by remedial works and increased capacity will be gained to support patient flow.

Risk 1219 – Insufficient workforce to deliver services required for "Recovery" and the continued response to COVID-19	Director of Workforce and OD	New	23/09/21	This new risk replaced 1018 and reflects the risk in respect of workforce availability to deliver the services required for the continued response to COVID-19, as outlined in the Health Board's Annual Recovery Plan for 2021/22. A number of actions are in place including development of a strategic recruitment strategy for delivery within year with monthly check of progress against actions, maximising use of temporary workforce availability, aligning funded establishment and unfunded posts to understand "workforce gap", engaging with HEIW and universities on medical, nursing, allied health professionals, health care support and pharmacy programmes, Medical workforce across USC being reviewed, working with all Wales colleagues to develop incentivisation for bank work to support in times of increased demand, and focussing on Workforce Plan alignment to predicted/possible scenario.

Note 2 - De-escalated/Closed Risks

Since the previous report to Board in July 2021, the following 11 corporate risks have been closed/de-escalated:

Risk	Lead Director	Close/De-escalated	Date	Reason
624 - Ability to maintain and address backlog maintenance and develop infrastructure to support long term strategic objectives	Director of Strategic Development & Operational Planning	Closed	04/08/21	The Executive Team agreed to close this as a principal risk 1196 (on the Board Assurance Framework) has been assessed in respect of the insufficient investment for the appropriate facilities and digital infrastructure to an appropriate standard.
646 - Ability to achieve financial sustainability over medium term	Director of Finance	Closed	04/08/21	The Executive Team agreed to close this as a principal risk 1199 has been assessed in respect of the achieving financial sustainability.

634 - Overnight theatre provision in Bronglais General Hospital	Director of Operations	De-escalated to Directorate level	04/08/21	The Executive Team agreed to de-escalate this risk to Directorate level as way forward has been agreed. Risk will be closed when new system has been fully implemented.
1030 - Reputational risk if the Health Board is perceived to not deliver the mass vaccination programme	Director of Public Health	De-escalated to Directorate level	04/08/21	The Executive Team agreed to de-escalate this risk to Directorate level as the Mass Vaccination Programme has been successful and the Health Board has continually managed to respond to policy changes and manage supply issues. This risk has been within tolerance since May 2021.
853 - Risk that Hywel Dda's response to COVID-19 will be insufficient to manage demand	Director of Operations	Closed	04/08/21	The Executive Team agreed to close this risk as COVID-19 is part of the environment in which the Health Board operates within and the risk has been at tolerance since May 2020.
854 - Risk that Hywel Dda's Response to COVID-19 will be larger than required for actual demand	Director of Operations	Closed	04/08/21	The Executive Team agreed to close this risk as COVID-19 is part of the environment in which the Health Board operates within and the risk has been at tolerance since May 2020.
855 - Risk that the UHB will be unable to address the issues that arise in non-COVID-19 related services and support functions	Director of Operations	Closed	15/09/21	The Executive Team agreed to close this risk following a review by the Director of Operations that confirmed that COVID-19 is captured within other corporate and operational risks related to non-COVID-19 related services.
291 - Lack of 24 hour access to Thrombectomy services	Director of Operations	De-escalated to Directorate level	15/09/21	The Executive Team agreed to de-escalate this risk as all actions have been completed and whilst the risk is still considered high, it is recognised that this as a national issue and potentially part of a wider issue associated with access to tertiary centres.
750 - Lack of substantive middle grade doctors affecting Emergency Department services in WGH, with the risk of service closure	Director of Operations	De-escalated to Directorate level	06/10/21	The Executive Team agreed to de-escalate this risk to Directorate level. The Director of Operations is to explore whether a new risk in respect of middle grade capacity across all 4 main hospital sites should be assessed.

628 - Fragility of therapy provision across acute, community and primary care services	Director of Therapies and Health Science	De-escalated to Directorate level	13/10/21	This risk was de-escalated as deficits in all staffing groups is captured in the wider workforce corporate risk. It was also felt that the remaining outstanding action in respect of developing robust workforce plans was covered within the wider workforce corporate risk, and longer term within the workforce principal risk.
1163 - Risk to the delivery of the Health Board's draft interim Financial Plan for 2021/22 of a £25.0m deficit	Director of Finance	Closed	03/11/21	This risk will be replaced by 2 new risks. The first risk relates to the delivery of a deficit in line with our original planned position of £25m for 2021/22. The second risk relates to the increase in our underlying deficit as a result of not having delivered sufficient savings in 2020/21 and 2021/22, which may not be funded by additional allocations from Welsh Government.

Note 3 – Increase/decreases in Current Risk Score

Since the previous report to Board in July 2021, there have been changes to the following 2 risks.

Risk	Risk Owner	Previous risk Score	Risk Score Nov-21	Date	Reason
1027 - Delivery of integrated community and acute unscheduled care services	Director of Operations	**4x4=16**	**5x4=20** ↑	07/11/21	This risk has increased to reflect the increasing levels of emergency demand. The case incidence of COVID-19 has increased within the community across West Wales which has led to an increase in COVID-19 cases in hospitals. This is compounded by an increase in infection outbreaks in wards which has a direct impact on acute care capacity which reduces admissions and discharges within the system. There is reduced staffed bed availability across both sectors which has led to increasing delays in the discharge pathway and increasing delays for patients accessing unscheduled care services due to reduced capacity at Emergency Departments. Available staffing resources continue to fall short of required levels and supply of short term and locum staffing resources remains variable. The indirect impact of COVID-19 has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. The situation remains fluid and changeable.

1048 - Risk to the delivery of planned care services set out in the Annual Recovery Plan 2021/22	Director of Operations	**4x4=16**	**5x4=20** ↑	07/11/21	The prevalence of COVID-19 has increased in recent months and this has had an impact of inpatient pathways which has led to a number of temporary ward closures across all sites associated with COVID outbreaks and the impact of wider urgent and emergency care pressures on the planned care patient pathway. Limits to staffing resource both in theatre, and post operatively, was a challenge before COVID-19. The additional factors of providing separate staffing teams for red and green areas, is an added challenge and has shaped the model of provision suggested on each site. It is evident that our realisable capacity in the short term will not match that available prior to March 2020. The plans we have outlined do however reflect the maximum capacity we can achieve within the footprint of our existing hospital sites. Whilst the plan for increased delivery of elective work (outlined within the HDUHB Annual Plan) is progressing in accordance with the plan outlined, challenges and risks around availability of supporting bed and theatre capacity remain which limits the ability of our clinical teams to expand activity delivery to pre-COVID-19 levels, and further waves of the pandemic. There is a significant challenge across the Urgent and Emergency Care system which continues to impact upon planned care pathways.

Argymhelliad / Recommendation

The Board is asked to consider whether it has sufficient assurance that principal risks are being assessed, managed and reviewed appropriately/effectively through the risk management arrangements in place, noting that these have been reviewed by Board level Committees.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Corporate Risk Register
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. Risk appetite can be defined as '*the amount of risk that an organisation is willing to pursue or retain*' (ISO Guide 73, 2009). ISO (2009) define risk tolerance as '*the organisation's readiness to bear a risk after risk treatment in order to achieve its objectives*', however it can be simpler to see it as a series of limits such as lines in the sand beyond which the organisation does not wish to proceed.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Team

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 of individual risks.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.

Gweithlu: **Workforce:**	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Risg: **Risk:**	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Cyfreithiol: **Legal:**	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Enw Da: **Reputational:**	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Gyfrinachedd: **Privacy:**	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Cydraddoldeb: **Equality:**	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.

Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Nov-21	Trend	Target Risk Score	Risk on page no...
1027	Delivery of integrated community and acute unscheduled care services	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4x4=16	5×4=20	↑	3×4=12	3
1048	Risk to the delivery of planned care services set out in the Annual Recovery Plan 2021/22	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4x4=16	5×4=20	↑	3×4=12	7
684	Lack of agreed replacement programme for radiology equipment across UHB	Carruthers, Andrew	Service/Business interruption/disruption	6	5×4=20	5×4=20	→	3×4=12	10
117	Delays in transfers to tertiary centres for urgent cardiac investigations, treatment and surgery	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4x5=20	4×5=20	→	2×5=10	13
1219	Insufficient workforce to deliver services required for "Recovery" and the continued response to COVID-19	Gostling, Lisa	Workforce/OD	8	New	4×4=16	N/A	3×4=12	18
1032	2021/22 Operating Plan Delivery - Timely access to assessment and diagnosis for Mental Health and Learning Disabilities clients	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×4=16	4×4=16	→	3×4=12	22
813	Failure to fully comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO)	Carruthers, Andrew	Statutory duty/inspections	8	3×5=15	3×5=15	→	1×5=5	25
451	Cyber Security Breach	Thomas, Huw	Service/Business interruption/disruption	6	3×4=12	3×4=12	→	3×4=12 Accepted	30
129	Ability to deliver an Urgent Primary Care Out of Hours Service for Hywel Dda patients	Carruthers, Andrew	Service/Business interruption/disruption	6	4×3=12	4×3=12	→	3×3=9 Accepted	34
1218	Significant pressures expected from RSV and other respiratory viruses on Paediatric Services	Carruthers, Andrew	Service/Business interruption/disruption	6	New	4×3=12	N/A	3×3=9	39
633	Ability to meet the 75% target for waiting times for 2020/21 for the new Single Cancer Pathway (SCP)	Carruthers, Andrew	Quality/Complaints/Audit	8	3×4=12	3×4=12	→	3×2=6	42
1016	Increased COVID-19 infections from poor adherence to Social Distancing	Rayani, Mandy	Safety - Patient, Staff or Public	6	2×5=10	2×5=10	→	2×5=10	45

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Ma	Tends to be detailed
2nd Line	Corporate O	Less detailed but slightly
3rd Line	Independent	Often less detail but truly

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

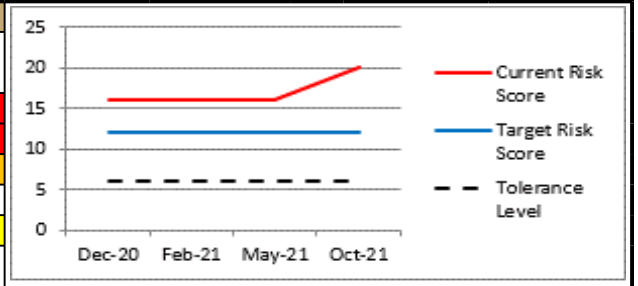
NB Assurance Map will tell you if you have

Key - Control RAG rating	
LOW	Significant concerns over
MEDIUM	Some areas of concern ov
HIGH	Controls in place assessed
INSUFFICIENT	Insufficient information a

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Nov-21
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Dec-21

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 increasing fragility within the urgent and emergency care (UEC) system, increasing levels of demand above staffed capacity, the impact of COVID-19 on available whole system bed and staffing resources and delays in discharges across the care system which are beyond the direct influence of the Health Board. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increased incidents of a serious nature relating to ambulance handover delays 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.

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



Does this risk link to any Directorate (operational) risks?	yes
Trend:	⬆

Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
Levels of emergency demand continue to increase. The case incidence of COVID-19 has increased within the community across West Wales which has led to an increase in covid cases in hospitals. This is compounded by an increase in infection outbreaks in wards which has a direct impact on acute care capacity which reduces admissions and discharges within the system. There is reduced staffed bed availability across both sectors which has led to increasing delays in the discharge pathway and increasing delays for patients accessing unscheduled care services due to reduced capacity at ED departments. Available staffing resources continue to fall short of required levels and supply of short term and locum staffing resources remains variable. The indirect impact of COVID-19 has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. The situation remains fluid and changeable.	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 as the Autumn period has progressed.

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	**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.	# Data has demonstrated that targeted improvement is required across our UEC system to reduce conveyance, conversion and discharge levels to facilitate improvements in the management of our	To consider alternative models of medical oversight i.e service level agreement with local GPs and HB salaried community GPs	Dawson, Rhian	30/11/2021	Pending confirmation indemnity for the local GPs to deliver.
		Refer CRR 1219 detailing actions to address insufficient workforce to support delivery of essential services.	Gostling, Lisa	31/03/2022	Ref CRR 1219 for detailed progress.

# Discharge lounge takes patients who are being discharged. # The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles. # Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites. # Regular training on discharge planning and complex care management is provided to ward based staff through Community Discharge Liaison teams, Social services and the Long Term Care Team support. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Escalation plans for acute and community hospitals (within limits of staffing availability). # Winter Plans developed to manage whole system pressures. # Joint workplan with Welsh Ambulance Services NHS Trust. # 111 implemented across Hywel Dda. # Transformation fund bids in relation to crisis response being implemented across the Health Board. # IP&C support for care homes to avoid outbreaks. # 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) programme # Supernummery HCSWs aligned to the acute response teams to support failing community care capacity # Support for complex discharge caseload management tool (SharePoint) appointed # LFT testing introduced for staff # 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. # Staff visiting restricted to those 'who have purpose' # SDEC models continuously reviewed and refined to maximise impact	Complex frail population, maximise enhanced 'front door' turnaround within max 72 hours and improved discharge coordination. # Fragility of Care Home Sector exacerbated by Covid related issues such as financial viability, increasing number of care home bed voids following outbreaks. # Significant paucity of domiciliary care/social care availability due to recruitment and retention of staff exacerbated by increased staff absences due to the TTP process. # Inability to secure GP medical oversight for step down/ intermediate care beds. # Inability to secure multidisciplinary resource to support discharge to assess model in the community. # Nurse staffing availability to ensure safe levels of care as a consequence vacancies and COVID 19 related absence across acute and community care. # Reduced acute bed availability due to impact of COVID-19 outbreaks and reduced staffing availability. # COVID-19 has further exacerbated workforce capacity and availability of bank and agency staff	To encourage and support staff to participate in the UHB's Covid-19 vaccination programme.	Jones, Keith	31/12/2021	Undertaken through general communications and line management.
		Explore service provision in the community for people pending ambulance conveyance, and where conveyance is not possible to manage ambulance handover delays	Dawson, Rhian	31/12/2021	Work has started on scoping the provision.
		Recruit additional workforce in line with safe staffing requirements for 28 beds in Amman Valley Hospital	Dawson, Rhian	31/12/2021	Recruitment process underway
		Development of enhanced Bridging Service and to actively recruit HCSWs to support domiciliary care services	Lorton, Elaine	30/11/2021	Recruitment of HCSW underway. 1st recruitment campaign commenced and currently going through pre-employment checks with 2nd campaign launched.
		Create live UEC performance dashboard.	Dawson, Rhian	31/12/2021	UEC Dashboard currently under development.
		Recruitment to UEC Programme Management Office	Dawson, Rhian	31/01/2022	Recruitment process underway
		Implementation of 111 First and local streaming hub as well as enhancing Same Day Emergency Care (SDEC) provision to reduce conveyance and conversion	Dawson, Rhian	31/03/2023	Recruitment underway. £3.4m awarded by WG for UEC Programme.
		Explore and gain approval for funding for 2wte COTE consultants	Dawson, Rhian	31/03/2022	Scoping underway
		To implement the Standard for Discharge to Assess in accordance with the WG Disharge Guidance	Dawson, Rhian	31/03/2025	Plan to be developed.
		Review ambulance handover procedure in conjuction with WAST and HB Review Escalation Policy	Passey, Sian	31/03/2022	Senior level discussions with WAST have been undertaken in respect of ambulance handovers. All sites endeavour to cpmply with Red Release policies wherever possible.

on admission avoidance.	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. # Inability to increase capacity in Amman Valley Hospital by 8 beds. # No live dashboard	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 medically fit patients	Passey, Sian	31/12/2021	Continuous discussions with Heads of Nursing and regular operational consideration given to scoping patient profile and pathways in accordance with provisions with the WG Essential Services Framework.			

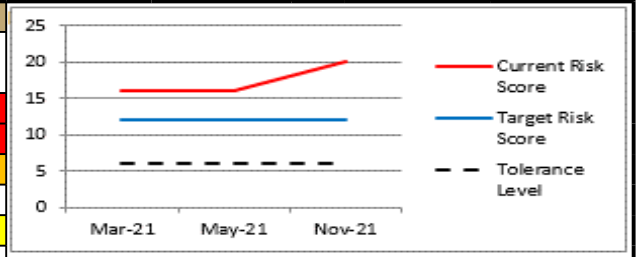
ASSURANCE MAP						Gaps in ASSURANCES			
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**	**Control RAG Rating (what the assurance is telling you about your controls**	**Latest Papers (Committee & date)**	**Identified Gaps in Assurance:**	**How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
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:	Mar-21	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Nov-21
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Dec-21

Risk ID:	**1048**	**Principal Risk Description:**	There is a risk there will be disruption to the delivery of planned care services set out in the Annual Recovery Plan 2021/22. This is caused by the impact of urgent and emergency care pressures (as reflected in Risk 1027) and a continuing significant deficit in available staffing resources to support green pathways for urgent and cancer pathway patients. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increasing pressure of adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators.

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:	



Does this risk link to any Directorate (operational) risks?

Rationale for CURRENT Risk Score:

The prevalence of COVID-19 has increased in recent months and this has had an impact of inpatient pathways which has led to a number of temporary ward closures across all sites associated with COVID outbreaks and the impact of wider urgent and emergency care pressures on the planned care patient pathway.

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

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

There is a significant challenge across the Urgent and Emergency Care system which continues to impact upon planned care pathways.

Rationale for TARGET Risk Score:

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Comprehensive daily management systems in place to manage planned care risks on daily basis including multiple daily multi-site calls in times of escalation.	# Limited impact of the wider urgent and emergency care plan in	Plan for Q1-4 levels of capacity to be agreed via 2021/22 Annual Plan	Jones, Keith	Completed	Plan confirmed via Annual Recovery Plan.

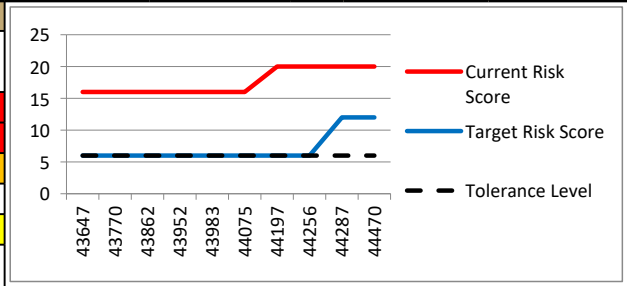
# Prioritised review of patients based on an agreed risk stratification model. # Provision of 'green' pathway beds on 4 sites (where staffing allows). # Discharge lounge takes patients who are being discharged. # The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Escalation plans for acute and community hospitals (within limits of staffing availability). # Outpatient transformation programme in place with a continuing focus on alternatives to face to face delivery of outpatient care to enable increases in care volumes delivered. # Risk assessed establishment of AMBER post-operative critical care pathway as a more practical alternative to dedicated GREEN post-operative critical care pathway to increase the flow of appropriate patients. # Robust sickness absence management arrangements in place. # Comprehensive programme of outsourcing of planned care volumes in place utilising capacity available vis independent sector providers # Weekly review of outsourcing volumes and further opportunities progressed jointly by Planned Care and Commissioning teams.	reducing capacity pressures on acute sites and the ability to protect sufficient 'green' pathway capacity for elective patients. # Nurse staffing availability to ensure safe levels of care as a consequence vacancies and COVID 19 related absence across ward, critical care and theatre areas # Reduced acute bed availability due to impact of COVID-19 outbreaks and reduced staffing availability # COVID-19 has further exacerbated workforce capacity and availability of bank and agency staff who would be available. # Limitations of the physical estate on hospital sites to enable protected/dedicated green pathway critical care facilities # Timeliness of the All Wales Commissioning Framework to support rapid decision making and commissioning of independent sector activity levels when supported by non-recurrent funding released part-way through the year. # Operational delivery challenges (staffing) experienced by independent sector providers which, to date	Opportunities to enhance dedicated green pathway capacity across sites are subject to continuous review and discussion between respective acute sites and Planned Care Directorate	Jones, Keith	Completed	Green pathways established on 4 sites although: # WGH & PPH orthopaedic IP pathways suspended due to urgent and emergency care pressures. # Intermittent impact on cancer surgical volumes due to overall emergency and COVID impact on critical care.
		Refer CRR 1219 detailing actions to address insufficient workforce to support delivery of essential services.	Gostling, Lisa	31/03/2022	Ref CRR 1219 for detailed progress.
		Assistant Director of Nursing (Acute Services) leading a review of overall acute nurse staffing resource availability with support from acute site and directorate heads of nursing	Jones, Keith	Completed	Staffing deficits confirmed. Current delivery progressing in accordance with available staffing.
		To remind services to of the need to undertake robust sickness absence management to ensure staff are able to return to work safely and promptly	Jones, Keith	Completed	Actioned however impact of updated shielding guidance continues to limit the return of affected staff.
		Planned Care Recovery programme to be formally established within HB, setting out governance arrangements at Gold, Silver and Bronze levels.	Jones, Keith	Completed	Plan for 2021/22 confirmed. Longer term recovery proposals (beyond March 2022) currently being reviewed via IMTP development.
		To support routine testing of staff	Carruthers, Andrew	Completed	LFT rolled out across selected planned care wards and clinical areas.
		Development of ward based post operative enhanced care pathways as an alternative to dedicated green critical care facilities.	Jones, Keith	~~31/05/2021~~ Timelines dependent on staffing availability	Implemented at PPH & BGH. Development continuing at other sites, timelines dependent on staffing availability.
		Development of plans to enhance capacity through consideration of demountable facilities and opportunities to develop regional solutions for key pathways (eg cataract surgery).	Jones, Keith	Completed	Proposal submitted to WG Apr21. Non-recurrent funding for 2021/22 confirmed by WG. Formal tenders from potential providers currently being assessed.
ASSURANCE MAP	**Control RAG** **Latest**	**Gaps in ASSURANCES**			

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

Date Risk Identified:	Jan-19	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Oct-21
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Nov-21

Risk ID:	**684**	**Principal Risk Description:**	There is a risk radiology service provision from breakdown of key radiology imaging equipment (specifically insufficient CT capacity UHB-wide, and the general rooms and fluroscopy room in Bronglais). This is caused by equipment not being replaced in line with RCR (Royal College of Radiographers) 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.

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



Does this risk link to any Directorate (operational) risks?	644

Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
The UHB's stock of imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites which has a significant impact on the UHB's ability to meet its RTT target and impact to patients can include delays in diagnosis and treatment. Presently equipment downtime is frequently up to a week which can put significant pressures on all diagnostic services. Whilst activity has decreased due to COVID, scanning of COVID patients requires more time than non-COVID patients, which will become an issue as requests for diagnostics for non-COVID patients increase as other services resume. Commissioning of agreed equipment has also been delayed as a result of COVID and this remains dependent external factors. Radiology has been asked to increase its service provision to other Directorates which it is currently unable to provide due to limitations on current equipment, however the demountable CT-scanner will provide much needed resilience at GGH. The risk score remains at 20 as a funding has been agreed for 2 out 5 required CT scanners for Hywel Dda, however these will not be commissioned until end of Q3 and Q4 therefore the benefits will not be realised and the likelihood will not decrease until these are in place. Whilst some contingency has been provided by a scanner in a demountable unit this does not provide full cover for acute care (not suitable for complex care).	Until a formal replacement programme in place, it will not be possible to bring this risk within tolerance and therefore the target score has increased to 15 as it should be possible that when the new equipment is commissioned, this will slightly reduce the risk. 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.

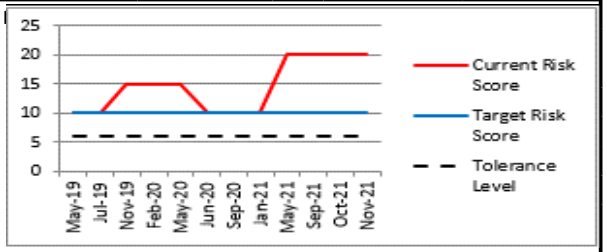
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do	**How and when the Gap in control be addressed** 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) - to be commissioned by Dec21 and Mar22. # Additional CT secured in the form of a mobile van in December 2020.	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.	Work with planning colleagues about sourcing capital funding through DCP and AWCP.	Evans, Amanda (Inactive User)	~~30/06/2019~~ ~~01/04/2020~~ ~~31/12/2020~~ ~~31/03/2021~~ 31/03/2023	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.
		Monthly project meeting to discuss commissioning of agreed equipment with estates, planning and manufacturers.	Evans, Amanda (Inactive User)	~~31/12/2020~~ ~~30/08/2021~~ 31/03/2022	Commissioning equipment is dependent on lockdown measures in and outside of UK and contractor availability to undertake work. Some equipment has already been commissioned, however still awaiting completion of project on MRI in WGH. The commissioning of the 2 CT scanner has been added to project meeting.

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:	Feb-11	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Nov-21
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Dec-21

Risk ID:	**117**	**Principal Risk Description:**	There is a risk avoidable patient harm or death and serious deterioration in clinical condition, with patients having poorer outcomes. This is caused by the delay in transfers to tertiary centre for those requiring urgent cardiac investigations, treatment and surgery. This could lead to an impact/affect on delayed treatments leading to significant adverse clinical outcomes for patients, increased length of stay, increased risk of exposure hospital acquired infection/risks, impaired patient flow into appropriate tertiary cardiac pathways with secondary care CCU and cardiology beds exceeding capacity and inhibiting flow from A&E/Acute Assessment wards.

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	⟷



Does this risk link to any Directorate (operational) risks?

Rationale for CURRENT Risk Score:

The UHB has historically experienced delays in transferring patients to Swansea Bay UHB (SBUHB) tertiary cardiac service for a range of cardiac investigations, treatments and surgery, in particular transfer delays for ACS/NSTEMI patients requiring tertiary centre angiography/coronary revascularisation within 72 hours of presentation to local secondary care hospital (NICE). The ACS/NSTEMI Treat & Repatriate service established in January 2019 provided 6 ring-fenced beds at PPH and improved transfer times for BGH and WGH patients in particular. Cessation of the Treat & Repatriate service due to COVID acute site pressures at PPH in 2020 has seen a return to increased numbers of patients awaiting prolonged periods for transfer from all 4 acute hospital sites, which is further compounded by acute sites pressures at Morriston Hospital - the risk likelihood has consequently been increased from 2 to 4 to reflect current waiting times averaging 16.9 days based Q4 2020/21 audit.

Rationale for TARGET Risk Score:

The target score was reduced to 10 in March 2019 on account of the anticipated benefits of the Regional N-STEMI 'Treat & Repat' arrangement. The service initiated in January 2019 saw a reduction in transfer wait from an average of 10.7 to 4 days by April 2019. Whilst the PPH 'Treat & Repat' service is currently suspended, it is anticipated that resumption of this approach would yield the same improvement.

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	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**

# All patients are risk-scored by cardiac team at SBUHB on receipt of patient referral from HDUHB and discussed at weekly Regional MDT. # Weekday telephone call between SBUHB Cardiology Coordinator and all 4 hospital Coronary Care Units (CCUs) to review patients awaiting transfer, in particular the progress on identified work-up actions. # Medical and nursing staff review patients daily and update the Sharepoint referral database as appropriate to communicate and escalate changes in level of risk/priority for patients awaiting transfer. # Bi-monthly operational meeting with Swansea Bay UHB (SBUHB) to monitor activity/patient flow and address associated risks/issues. # Increased numbers of patients waiting / prolonged transfer delays are identified on daily Sitrep Calls and escalated by HDUHB Cardiology Clinical Lead / SDM to SBUHB Cardiology Clinical Lead / Cardiology Manager. # Reporting arrangements in place to monitor emergency and elective waiting times.	Lack of capacity in tertiary centre to manage a range of specialised cardiac investigations, treatments and surgery. Lack of cardiac catheter capacity in HDUHB to reduce reliance on tertiary centre angiography. Lack of theatre / pacing workforce capacity in HDUHB to reduce reliance on tertiary centre pacing. Lack of CT Coronary Angiography capacity in HDUHB to reduce reliance on in-house and SBUHB angiography. Suspension of PPH ACS/N-STEMI 'Treat & Repat' pathway in 2020.	Increase in-house CT Coronary Angiography (CTCA) capacity. As a less invasive/lower risk diagnostic, this will release and prioritize in-house and tertiary Percutaneous Coronary Angiography capacity for those patients who require it and thereby reduce transfer delays.	Smith, Paul	~~31/01/2019~~ 31/12/2021	SBAR development delayed during 2020 due to COVID pressures. Development of local CTCA is a key priority within the ARCH Cardiology Programme in 2021/22. Indicative investment for CTCA highlighted in IMTP - detailed business case in development and scheduled for completion in December 2021 in support of IMTP.
		Develop long term Regional Cardiology Plan.	Carruthers, Andrew	~~30/09/2019~~ 31/12/2022	Decision taken not to establish a regional Cardiac Network/Collaborative in 2019. Development of long term regional plan for cardiology historically overseen by Joint Regional Planning and Delivery Forum and Committee and ARCH workstreams, but progress delayed/activity suspended during COVID. Cardiology Clinical Lead and SDM engaging with the ARCH Cardiology Programme re-established in Aug '21. ACS, CT Coronary Angiography, Cardiac MRI, Pacing and Cardiac Physiology workforce identified as the key priority areas for 2021/22.

Increase in-house cardiac pacing capacity as part of a broader plan to repatriate the pacing LTA from SBUHB.	Smith, Paul	~~31/10/2019~~ 31/12/2021	Historic Pacing SBAR approved by Executive Team in Sep '19 supporting repatriation of Pacing (LTA) from SBUHB - this plan to phase repatriation from Spring 2020 was suspended by COVID throughout 2020. Development of local Pacing is a key priority within the ARCH Cardiology Programme in 2021/22. Indicative investment for Pacing highlighted in IMTP - 2019 SBAR currently being updated and scheduled for completion in December 2021 in support of IMTP.
Re-establish HDUHB ACS/N-STEMI Treat & Repatriate Pathway	Smith, Paul	~~01/07/2021~~ 30/12/2021	Development of Regional ACS pathway is a key priority within both the Cardiology Pathway Transformation Project (2021/22) and the ARCH Cardiology Programme. Indicative investment for restoration of Treat & Repatriate facility/service highlighted in IMTP - detailed business case in development and scheduled for completion in December 2021 in support of IMTP.

						Review ACS/NSTEMI Pathway and longer term plans/requirements to achieve NICE NG185 ACS recommendations.	Smith, Paul	31/12/2021	Development of Regional ACS pathway is a key priority within both the Cardiology Pathway Transformation Project (2021/22) and the ARCH Cardiology Programme. Cardiology Pathway Transformation Project (2021/22) currently mapping / re-mapping current pathway and developing gap analysis in support of NICE NG185 ACS compliance. Indicative investment for future pathway re-design highlighted in IMTP - detailed business case in development and scheduled for completion in December 2021 in support of IMTP.
						Increase in-house diagnostic Percutaneous Coronary Angiography. This will address current in-house capacity deficit due to patient social distancing as well as reduce reliance on tertiary pathway and thereby reduce transfer delays.	Smith, Paul	31/12/2021	Development of Regional ACS pathway is a key priority within both the Cardiology Pathway Transformation Project (2021/22) and the ARCH Cardiology Programme. Consideration of priority/necessity/viability of developing HDUHB PCI service currently on-going within ARCH Steering Group / ARCH ACS Project group.
ASSURANCE MAP				**Control RAG Rating (what the assurance is telling you about your controls**	**Latest Papers (Committee & date)**	**Gaps in ASSURANCES**			
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**			**Identified Gaps in Assurance:**	**How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
Performance indicators for Tier 1 targets.	Daily/weekly/monthly/ monitoring arrangements by management	1st				Lack of oversight at the Board and Committees.				
	Audit of N-STEMI referral undertaken by Cardiology Clinical Lead/SDM on quarterly basis	1st								

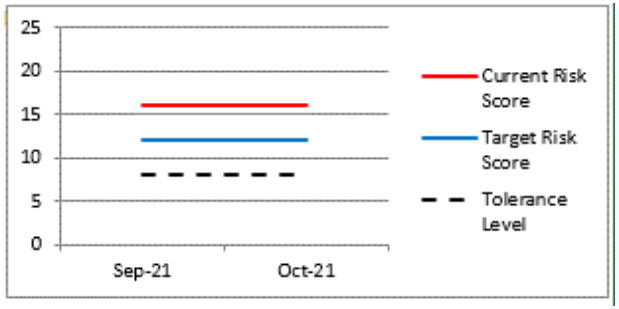
IPAR Performance Report to SDOPC & Board	2nd						
Monthly oversight by WG	3rd						

Date Risk Identified:	May-21	**Executive Director Owner:**	Gostling, Lisa	**Date of Review:**	Oct-21
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	People, Organisational Development and Culture Committee	**Date of Next Review:**	Nov-21

Risk ID:	**1219**	**Principal Risk Description:**	There is a risk there will be insufficient workforce available to deliver services required for "Recovery" and the continued response to Covid and other respiratory infections, as outlined in the UHB's annual plans 2021/22. This is caused by new variants of COVID, increase in the severity and dispersal of respiratory viruses within the population (in children and adults) which could mean an increase in infections and outbreaks within acute, community and social care facilities. Further to this, a lack of alignment of information between service, workforce and finance on workforce requirements for unfunded service pathways could further jeopardise workforce availability in areas of need. This could lead to an impact/affect on the Health Board's ability to staff pathways for COVID, field hospitals, surge capacity within general hospitals, community hospitals, paediatric units effectively managing the impact from of outbreaks, delivering a mass vaccination programme and the delivery of planned care, as well as increased sickness absence directly, and increased self-isolation of staff, and limiting the ability to recruit new staff quickly to provide additional support.

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

No trend information available.



Does this risk link to any Directorate (operational) risks?	1186	**Trend:**	⟷

Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
Given the workforce starting position in terms of gaps within our Registered Nursing workforce, increasing demands to restart services, the current risk score is considered to be "likely" and has the potential to have a "major" impact. The result of an outbreak would see a significant number of key staff unavailable which would impact on service delivery and stretch service provision. Unfunded service provision could impact on understanding of workforce availability and create misalignment of workforce availability.	The Target Risk score indicates the likelihood of the risk occurring (to note there have been minor outbreaks of new variants in Wales) which depending on the efficacy of the vaccine against this, it may be that there could be concerns for the re-start of services or more specifically of a winter surge developing when recovery activity has fully commenced. Therefore the probability sits between 25-75% (and therefore is relatively unknown at this juncture) which we hope will be mitigated by the actions noted below. What is known is that services do have unfunded pathways and any resourcing activity has the potential to divert resources away from these areas (needs assessment is required.)

Key CONTROLS Currently in Place:	**Gaps in CONTROLS**			
(The existing controls and processes in place to manage the risk)	**Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**

Organisational Governance Structure People, Organisational Development and Culture Committee (PODCC) Workforce Planning Team Inter-Team & Professional Groups & Planning Objectives Establishment control Agency usage Bank Utilisation & ongoing onboarding of supply Efficient Rostering practice Roll out of new rostering system Overview of organisation and service wide risks (assessment of each service area based on workforce availability) Continuous process of assessment of services to be stood down and deployment options based on service needs Continuous prioritisation of recruitment/onboarding of new employees to the highest areas of risk in terms of maintaining service delivery Temporary Workforce Utilisation reports shared regularly to monitor levels of supply.	An organisational wide escalation plan (based on a detailed assessment of Recovery Plans and workforce requirements, set against an escalation plan for COVID resurgence). Establishment control cannot be relied on due to temporary changes linked with covid and pathways. Linked with service pressures increased demand is placed in terms of workforce which has not been planned for delivery in year.	IMTP Plan addendum details - 1)Recovery Plan & Workforce Requirements 2) COVID Planning objectives & Workforce Requirements 3) Phased Plan for Covid escalation 4) New Programmes & Projects Timelines & Workforce Requirements explored for alignment to Recovery & COVID Plans. Monthly assessment of demand to be undertaken linked with service discussions in preparation for current demands and anticipated increased pressure in Winter.	Walmsley, Tracy	~~31/10/2021~~ 30/11/2021	Keeping abreast of workforce changes in terms of demand & supply i.e. bridging service, demountable at PPH, NSL. Gap in knowledge - winter planning workforce activity linked to any WG funding for 2021/22.
		Development of strategic recruitment strategy for delivery within year with monthly check of progress against actions	Thomas, Annmarie	~~31/10/2021~~ 30/11/2021	As above, and recruitment plan for bridging service in place awaiting confirmation of target numbers. Responding to specific requests for additional workforce requirements in a number of areas e.g. Family Liaison Officers, Facilities, Vaccination Service, TTP etc. Strategy in progress and will be linked to IMTP Workforce Planning Methodology (MDS for WG etc).
		Assessment of services to be stood down and deployment options based on service needs.	Walmsley, Tracy	15/11/2021	RSV Surge Plan completed by 31/10/21. Developing workforce plan for FH if reopening is required.
		Maximise use of temporary workforce availability to include Bank, Overtime and Agency by undertaking monthly assessment of resourcing pipeline and continuous review of Bank HCSW recruitment	Thomas, Annmarie	31/03/2022	Temporary Workforce Utilisation maximised via continuous recruitment to bank, engagement with additional agencies on the framework, revisiting off-contract booking protocols. Flexible Incentive rate introduced for fixed period. C. 140 onboarding to Bank HCSW roles.
		Align Funded Establishment & Unfunded posts to understand "workforce gap". Working with HON, CH on NSL levels alignment & HCSW gaps (funded & funded) with Finance colleagues.	Walmsley, Tracy	Completed	Completed assessment. Fed into Silver. Agreed to manage at risk for each service.

Develop team around the patient model. Group established and Plan on a Page developed. Band 4 roles being developed; will align to work above on funded and unfunded establishment.	Passey, Sian	~~31/10/2021~~ 30/01/2022	Work ongoing. Capacity to support development noted as a concern. Alignment of resources & support needed.
Engagement with HEIW & Universities on Medical, Nursing, AHP/HCS & Pharmacy programmes to include work linked to the Strategic Education Group and specific discussions with HEIW on more Band 4 roles and medical workforce planning. Regular contact with HEIW on all matters related to workforce planning - monthly & quarterly.	Walmsley, Tracy	~~30/09/2021~~ Ongoing to 30/01/2022	No specific feedback gathered on approach to workforce planning for medical workforce from HEIW. Met September will continue to connect with All Wales workforce planning network. Connected with Swansea University colleagues. Require support to access data on commissioning to align to locality and develop alignment to Education & Commissioning Work.
Medical workforce across USC being reviewed. Ensure baseline assessment is understood across UHB. Discussions on priority gaps/issues in Pembrokeshire progressing Further work in Carmarthen and Ceredigion being planned. (Also linked to appointments/approach to Physician Associates (PAs) in UHB.)	Walmsley, Tracy	31/03/2022	Work to be discussed further. PA work making progress - rotations of PA into Secondary & Primary Care being planned. 19 PA's will be in post in Hywel Dda HB in Nov21 - this will be one of the largest cohorts of PA's across Wales. EOI from PA's for 22/23 being developed - decision on corporate/local funding will be required. Capacity to progress work on medical workforce planning from all partners - assessing approach.
Review need and work with all Wales colleagues to develop incentivisation for bank work to support in times of increased demand. If Wales wide incentive not agreed then support organisation to develop own local scheme which at each interval includes robust monitoring of success or otherwise	Morgan, Steve	30/11/2021	Awaiting All-Wales proposal to be developed and communicated. Interim Hywel Dda Flexible Incentive Rate introduced on a temp basis.

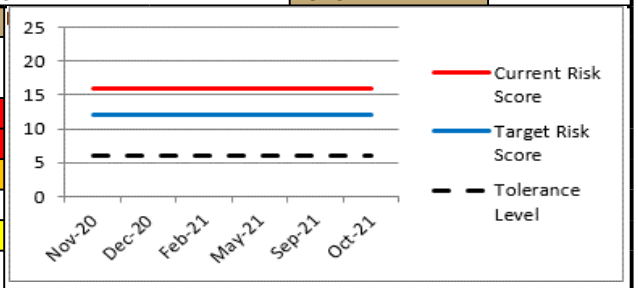
					Focus on Workforce Plan alignment to predicted/possible scenario. Assess risk and develop mitigating actions for future plans utilising refreshed ECT/Allocate data in Temp Workforce Tool to update workforce plan and assess gaps. Iterative cycle to update monthly.	Walmsley, Tracy	~~31/10/2021~~ 15/11/2021	Scenario of 925 beds being followed. Workforce gap is significant to meet need. Ongoing meetings with services to develop workforce plan and flag issues. Will feed into Workforce Planning Service Oversight Group when established.

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**
	Monitoring of workforce SIP and gaps in establishment control	1st				Specific Workforce Planning group	Workforce Planning Assurance group to be established	Walmsley, Tracy	31/12/2021	TOR drafted to be agreed.
	Workforce levels monitored at Professional Oversight Group for Workforce Planning & Service Oversight Group for Workforce Planning	2nd					Re-develop workforce plan based on gaps present to Workforce Bronze	Walmsley, Tracy	Completed	Actions above feed into this activity/HCSW FTC COVID also reviewed
	PODCC - IMTP Plan, Planning Sub Group	2nd								
	Workforce Planning Internal Audit (Substantial Assurance)	3rd								

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Oct-21
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Nov-21

Risk ID:	**1032**	**Principal Risk Description:**	There is a risk that the length of time MH&LD clients (specifically ASD, memory assessment and psychology services for intervention) are waiting for assessment and diagnosis will continue to increase during 2021/22. This is caused by new environmental (due to social distancing measures) constraints to undertake required face-to-face assessments and patients' reluctance to attend clinics due to the risk of COVID, as well as certain elements of some assessments being restricted due to other agencies, such as education, providing limited services at present. This could lead to an impact/affect on increasing delays in accessing appropriate diagnosis and treatment, delayed prevention of deterioration of conditions and delayed

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



Does this risk link to any Directorate (operational) risks?

Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
Referrals for ASD have continued throughout the pandemic at approximately the same level as pre-Covid. The service were experiencing significant waiting times as a result of demand levels. Due to the constraints to undertake the required face to face assessments, the implementation of social distancing and, in some instances patients reluctance to attend clinics due to the risk of Covid, has an impact on the services' ability to see the same volume of service users as they were previously able to. In addition, the estate footprint does not necessary lend itself to accommodate the social distance requirements and in some instances is not therapeutically beneficial.Certain elements of some assessments also being restricted due to other agencies, such as education, providing limited services.	The Directorate is aiming to restore pre-Covid levels of assessment and intervention. This 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.

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	**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	Social distancing measures reducing the available space/offices that can be used to meet clients face-to face. Certain elements of some assessments also being	Assess and source further IT requirements.	Carroll, Mrs Liz	Completed	Some further IT equipment has been received and distributed on a priority basis. The Directorate will now need to rationalise working from home/agile working in order to maximise the potential office/clinical space.

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 community support, well being 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. Paper was presented at the June Quality Safety and Experience Assurance Committee with a further update paper provided for the August meeting outlining control measures to manage the waiting times that the Directorate have at present.	assessments also being restricted due to other agencies, such as education, providing limited services. 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 client group.	Identify alternative venues/space to hold clinics.	Carroll, Mrs Liz	~~31/03/2021~~ 31/12/2021	Working with the Estates Department and exploring options with external partners. Regular meeting 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/Local Authority use of hubs.
		Head of Service to operationalise	Carroll, Mrs Liz	~~31/12/2020~~ 31/12/2021	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. Service specific template letters are being developed and initial conversations held with Informatics colleagues to progress.
		Appointment of Service Delivery Manager.	Carroll, Mrs Liz	Completed	Service Delivery Manager has now taken up post.
		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	This process has been enacted.
		Identify funding for Interim Clinical Psychologist lead post to assist with the waiting lists and service development.	Carroll, Mrs Liz	~~31/03/2021~~ 31/12/2021	Discussions taking place with Finance Business Partner to progress recruitment.

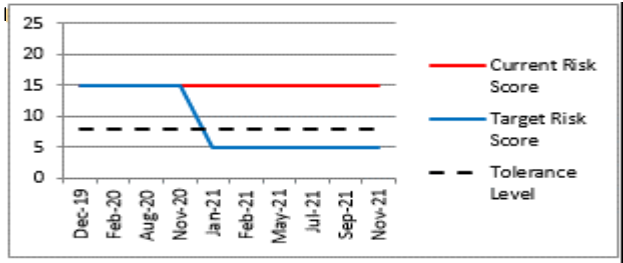
					Health Board is engaging in work with WG to benefit from additional support re waiting lists, demand and capacity planning and service mapping to meet the national standards and new Autism Code.	Carroll, Mrs Liz	~~30/04/2021~~ 31/12/2021	Health Board will be early pilot site providing an early offer for children and young people and their families, who otherwise would be referred for direct support to the NHS.

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)	System to improve analysis of patient experience	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.	Carroll, Mrs Liz	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.
	Monthly MH&LD Business Planning and Performance Group overseeing performance	2nd								
	MH&LD QSE Group overseeing patient outcomes	2nd								
	Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC	2nd								

Date Risk Identified:	Oct-19	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Nov-21
Strategic Objective:	3. Striving to deliver and develop excellent services	**Lead Committee:**	Health and Safety Committee	**Date of Next Review:**	Dec-21

Risk ID:	**813**	**Principal Risk Description:**	There is a risk of failing to fully comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO). This is caused by 1. A lack of available resources within the current operational maintenance function, to undertake a fully HTM compliant pre planned maintenance programme (PPM's) for all fire safety components across the entire HB's estate. 2: The age, condition and scale of physical backlog, circa £20m relating to fire safety across our estate significantly affects our ability to comply with the requirements of the RRO in every respect. 3: A lack of fire safety ownership and understanding of fire safety responsibilities at local hospital management level. This could lead to an impact/affect on the safety of patients, staff and general public, HSE investigations and further fire brigade enforcement, fines and/or custodial sentences, adverse

Risk Rating:(Likelihood x Impact)	
Domain:	Statutory duty/inspections
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	1×5=5
Tolerable Risk:	8
Trend:	⟷



Does this risk link to any Directorate (operational) risks?

Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
Despite significant progress being made since the NWSSP IA Fire Precautions Report in May 2017 with regards to the key recommendations, such as, the establishment of a fully resourced fire safety team, the embedding of appropriate reporting arrangements for fire safety and addressing the backlog of out of date fire risk assessments across the UHB. There are still some significant challenges faced by the UHB to fully comply with the fire safety order. Whilst the fire safety team are in a position to provide support now to the UHB in the form of expertise and technical knowledge. The UHB still needs to manage and address the physical backlog of fire safety across its estate. Also successfully embed an improved fire safety management culture and management ownership for fire safety. This is evident from the recent fire safety improvement notice (FSIN) served on the UHB in Sep19 for Withybush General Hospital and Glangwili General Hospital on 17Apr20.	Whilst it is likely that the UHB will address its staff shortfall issues in respect of fire safety for HTM compliance there are further improvements in culture and ownership for fire safety. It is the scale of physical backlog for fire safety compliance (circa £8m at present predicted to increase following additional surveys) that will remain until appropriate measures are put in place to address the deficit. Despite annual investment from statutory capital for fire safety components (circa £200k), the scale of current investment is clearly not adequate to address the true scale of backlog the UHB has.

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	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**

1.Pre Planned Maintenance (PPM) checks are carried out across the UHB on fire safety components. 2. A detailed physical estates backlog system is in place that identifies the scale (£) and risk of backlog for UHB. Data used to manage backlog maintenance & statutory decision making also regularly reported to WG. 3. Individual Fire Risk Assessments (FRA's) in place for all sites across the UHB identifying fire related risks. 4. Training Needs Analysis (TNA) for fire safety training in place, as defined in Fire Policy.	Significant staff shortfall to achieve agreed level of operational compliance (>85% target) for fire safety and other Health Technical Memorandum (HTM) engineering disciplines	Secure funding for the identified staffing gap identified in the operational staff gap analysis (based on size, geography and estate of the organisation)	Williams, Heather	Completed	A business case for additional staff support has been approved by the executive team subject to review by NWSSP-SES to substantiate its accuracy. Job descriptions have now been created for these roles, jobs are on Trac and interviews scheduled for April 2020.
5. UHB has implemented a governance structure for fire safety reporting. 6. Estate plans with fire zones, fire doors, fire compartmentation, fire infrastructure items (alarm and detection system). 7. UHB assesses its performance in respect of operational maintenance work carried out on fire safety components and presents this information as a formal paper at all UHB wide fire safety meetings. 8. Annual prioritisation of investment against high risk backlog.	Significant additional investment is required to address physical and engineering backlog shortfall for the UHB (approx circa £20m). Inability to allocate fire risk actions to appropriate owners on current fire risk assessment system hosted by NHS Wales Specialist Estates Services (NWSSP-SES). Inability to manage and control recommendations within the HB's own Fire Risk Assessments. Shortfall in advanced fire safety training especially in bariatric evacuation.	Reassess remaining backlog and develop a prioritised plan that will address the high risk areas and where possible, will align to TCS modernisation programme for the UHB. A Programme business case is being developed for the remaining acute hospital sites to identify key fire safety compliance issues in order to seek for additional capital funding.	Elliott, Rob	Completed	Additional surveys across the estate are being scheduled to assess the scale of fire backlog. The HB has now developed a detailed programme for both WBH and GGH to deal with all fire enforcement notices and letters of Fire Safety issued by the fire brigade (NWWFRS). In the case of WBH, Tripartite meetings with WG,HB and MWWFRS have taken place to agree a programme of investment and business case development. In the case of GGH the HB has submitted a detailed programme to MWWFRS which has been agreed. (Whilst verbal agreement been given by MWWFRS we await formal written confirmation) A meeting is planned for mid to late September on Tripartite bases to agree the same process as WBH.

Introduce a system to manage fire risk assessment recommendations more effectively. System to have the ability to assign risks to risk owners, to track/manage risk and to demonstrate progress on the actions.	Evans, Paul	~~31/03/2020~~ ~~31/07/2021~~ ~~30/06/2020~~ ~~28/01/2021~~ ~~30/06/2021~~ ~~30/10/2021~~ 27/12/2021	The fire team are utilising the current system as best as possible. An Excel system is being introduced (completion Jun20) however a more robust automated system is needed by the HB to track the significant number of actions. Progressing this has been delayed due to COVID-19, however quotes have now been obtained and are under discussion with the Director of Facilities. Approval has now been provided to purchase a system. Completion date for system trial on site by July 2021. System now being tested on site on a few Fire Risk Assessments, we plan to go fully live in Nov/Dec 2021.
Undertake a review of fire training to address identified shortfall in training provision and site fire management responsibilities.	Evans, Paul	Completed	A review has been undertaken and an action plan produced with the learning development teams. The HB has reintroduced the e-learning module for all levels of training instead of the face to face method which was suspended due to COVID-19, to improve fire training compliance which has dipped over recent months. A target of 85% for advanced training has been agreed, which will be achieved by Dec20. General fire safety training currently stands at 71%, which is not considered a concern at this stage and will now improve following the e-learning implementation. This will be reviewed monthly.

						Clarify responsibilities and identify management ownership for fire safety to facilitate an improved fire safety management culture across all sites. Revised date agreed as part of fire safety governance review.	Evans, Paul	Completed	MS Teams training programme now set up for managers to attend.
						Undertake a review of scale of work required to improve fire drawings in the UHB.	Evans, Paul	Completed	CAD officer now in post for West region and started his work programme. CAD officer for East commencing in Feb 2021.
						Review the compliance report to include the gaps associated with any risks on the fire safety components and not just levels of PPM performance.	Evans, Paul	Completed	An update template has already been produced and discussed amongst the fire and operational maintenance teams. The compliance paper is tabled at all Fire Safety Group meetings. This is now being taken forward as the model for the department. Next review of this is on the 27th Jan 2021.

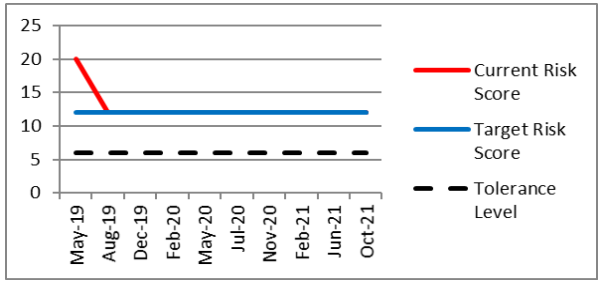
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**			**Identified Gaps in Assurance:**	**How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
Maintain 95% high risk PPM compliance. Maintain a zero or as low as possible number of outstanding fire risk assessments.	Bimonthly review of outstanding actions from fire risk assessments	1st			IA Fire Precautions Report - ARAC Jun18 Fire Action Update - H&SC - Sep21 & Nov21	General site management checks/ walkarounds on all sites	Responsibilities of site management to undertake routine workarounds to be implemented level 5 training	Evans, Paul	Completed	Site managers training now available via MS teams
	Site Fire wardens reporting fire safety issues	1st								
	Review of compliance through fire safety groups	2nd								
	Compliance reports regularly issued to HSEPSC	2nd								
	Fire inspections by Fire Service & Fire Improvement Notices	3rd								

NWSSP fire advisor inspections	3rd						
NWSSP IA Fire Precautions Follow Up May-18 - Reasonable Assurance	3rd						

Date Risk Identified:	May-17	**Executive Director Owner:**	Thomas, Huw	**Date of Review:**	Sep-21
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Sustainable Resources Committee	**Date of Next Review:**	Nov-21

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

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



Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
There are daily threats to systems which are managed by NWIS and UHB. Current patching levels within the UHB of is on average 89% for desktop/laptops and 89% for the server infrastructure (Aug21). The patching levels fluctuate during the month depending on the number of updates released by the 3rd party vendor. Alongside the fluctuations there is lack of capacity to undertake this continuous work at the pace required. Impact score is 4 as a cyber-attack has the potential to severely disrupt service provision across all sites for a significant amount of time, however the processes and controls in place have reduced the likelihood due to the improvements in patching.	Increased patching levels will help to reduce to impact of disruption from a cyber threat. However this work is continuous and is dependent on obtaining the appropriate level of resources to undertake the patching anti-virus work at pace. The target risk score of 12 reflects the wider risk to other applications not Microsoft. The Board have accepted that there is an inherent cyber risk to the organisation, and have therefore accepted that the risk cannot be reduced lower than 12.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Controls have been identified as part of the national Cyber Security Task & Finish Group. Continued rollout of the patches supplied by third party companies, such as Microsoft, Citrix, etc. £1.4m national investment in national software to improve robustness of NWIS. Further Task and Finish Group established to review the future patching arrangements within NHS Wales - this will lead future work locally to implement recommendations.	Lack of comprehensive patching across all systems used in UHB. Lack of staffing capacity to undertake continuous patching at pace. Lack of dedicated maintenance windows for updating critical clinical systems.	Work with system owners to arrange suitable system down-time or disruption.	Solloway, Paul	Ongoing	Patching policies have been created however little progress has been made due to lack of resources. Service catalogue creation is progressing well and this will be amalgamated with Information Asset Owners group to agree down-time for the key local systems. However patching KPI's will not be met until sufficient technical resources are in place.

Capital funding has been made available by WG in 2018/19 to improve cyber security - this will be used to purchase required software/equipment for penetration testing. Additional UHB funding.						Continue to implement the recommendations of the Stratia report	Solloway, Paul	Ongoing	The additional resources will be targeted towards the recommendations
						Implement the national products previously purchased (i.e. Security Information Event Management (SIEM)	Solloway, Paul	Ongoing	The additional resources will be targeted towards the recommendations
						Hire agency staff until such time that a permanent resource can be appointed.	Tracey, Anthony	Completed	The first round of appointments did not provide suitable candidates so agency staff will be used to provide progression of the recommendations.
						Appoint a dedicated cyber resilience resource to take forward the recommendations outlined within the Stratia report, and the recent Audit Wales Report, presented to ARAC.	Tracey, Anthony	Completed	The New Cyber Resource began in May 2021, and is in the process of addressing the Stratia report, and developing a Cyber Resilience Plan. The Digital Team, have also contracted with a third party company to work with us to develop our Cyber Resilience Plan.
ASSURANCE MAP						**Gaps in ASSURANCES**			
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance** **(1st, 2nd, 3rd)**	**Required Assurance** **Current Level**	**Control RAG Rating (what the assurance is telling you about your controls**	**Latest Papers (Committee & date)**	**Identified Gaps in Assurance:**	**How are the Gaps in ASSURANCE will be addressed** **Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
No of cyber incidents. Current patching levels in UHB. No of maintenance windows agreed with system owners. Removal of legacy equipment.	Department monitoring of KPIs	1st			External Security Assessment - IGSC - Jul 18 Update on WAO IT follow-up - ARAC - Oct19	National accreditation.	Progress the attainment of certificates and assurances as outlined by the National Cyber Security Centre (NCSC)	Tracey, Anthony	Ongoing	Regular reports on progress on External assessment to IGSC
	IGSC monitoring of cyber security workplan addressing recent internal and external audits/assessments	2nd								
	IGSC monitoring of National External Security Assessment	2nd								

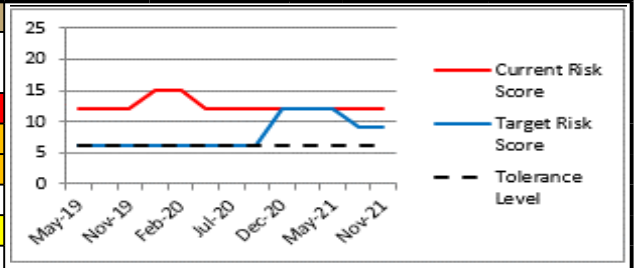
	Follow-up Information Backup, Disaster Recovery & Business Continuity and Data Quality: Update on Progress	3rd						

NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB) Oct17	3rd						
WAO IT risk assessment (part of Structured Assessment 2018	3rd						
Internal Audit IM&T Security Policy & Procedures Follow-Up - Reasonable Assurance	3rd						
IM&T Assurance - Follow Up - Reasonable Assurance - May20	3rd						
Cyber Security (Stratia Report) - Reasonable Assurance - Feb20	3rd						

Date Risk Identified:	Apr-17	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Nov-21
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Jan-22

Risk ID:	**129**	**Principal Risk Description:**	There is a risk of the inability to deliver an Urgent Primary Care Out of Hours Service for Hywel Dda patients. This is caused by a lack of available of labour supply as GPs near retirement age and pay rate differentials across Health Boards in Wales impact the UHB's ability to recruit in the mid-long term. In the short term, seasonal illnesses, continued COVID19 pressures, and upcoming Christmas holiday period could further compromise the ability to fill shifts. This, combined with possible impacts on in-hours provision, will result in a deteriorating workforce position. In addition, some clinicians may preferentially work 111 First shifts, as they are potentially much lighter (already seen in SBU). Seasonal illnesses, continued COVID19 pressures, and upcoming Christmas period could further compromise the ability to fill shifts. 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 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 may also result in unforeseen deterioration of an unmanaged condition in a patient, thus becoming more

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×3=15
Current Risk Score (L x I):	4×3=12
Target Risk Score (L x I):	3×3=9
26/11/2020 - Board 'Accept' Target Risk	
Tolerable Risk:	6
Trend:	⟷



Does this risk link to any Directorate (operational) risks?

Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
The COVID pandemic combined with the temporary overnight service changes has brought some respite to the service fragility, and this is reflected in the current risk score. Generally the rotas continue to be unstable, particularly at the weekends. Any further absence on out of hours provision is likely to rapidly result in further deterioration of the current position. As of Sep21 there has been no notable change/definite trend in the service fragility. Rotas continue to be fragile, particularly at weekends. The potential adverse affects of a third wave are currently being considered, combined with other seasonal pressures, including the potential affect of RSV.	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 this is further compounded by the need for salary staff to take annual leave and sessional staff to have time off to rest (particularly following the pressures of the Covid-19 pandemic). The August 2021 Bank Holiday rotas were still markedly reduced, despite the offer of Christmas rates (our highest hourly rates), which reflects exhaustion and burn out of clinicians. 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 requirements have been flagged as part of the IMTP. The Clinical Lead has 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. The potential adverse affects of the pandemic, plus RSV and Flu, are currently being considered, which should include further updates to the Exec Team. Target score has been reduced from 12 to 9 to reflect the 5 salaried GPs, on the assumption that they will complete recruitment. There is less of an improvement from this recruitment as it is being used to develop plans to re-open bases and provide better care, therefore the effect of the recruitment could be diluted through the expansion of the service.

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	**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 # Dedicated GP Advice sessions in place at times of high demand (mostly weekends). # Remote working telephone advice clinicians secured where required. # Additional remote working capacity has been secured to assist	The ability to influence workforce participation remains limited due to the lack of contractual agreements (reliance on sessional staff). 5 new	Ensure Transforming Clinical Services Programme incorporates a long term, viable plan for OOH.	Rees, Gareth	~~30/09/2020~~ 31/12/2021	Still awaiting decision/direction on integration into TCS, as well as considering the impact of the ongoing Covid pandemic.

clinicians who may be shielding/ isolating to continue to support operational demand. # Workforce support from 111 programme team in addressing OOH fragilities available if required. # Health Professional feedback form in use between clinicians, service management and 111 (WAST) leads. # WAST Advance Paramedic Practitioner (APP) resource enhanced to provide more flexibility. # 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. # Home working provision in place for GPs. # Agreed pathway for PPH Minor Injury Unit in place. # GP Hub in place where locum sessions can be accessed centrally to support service provision. # Ongoing recruitment campaigns in order to bolster the MDT model and maintaining service stability. # Use of telephone consultations for service delivery alongside remote working, which has increased by 60% due to the pandemic.	salaried GP may allow us to influence this positively. At present the staffing remains challenging, as we have lost the previous stability in the stable rota in Carmarthen. There are shortfalls in Pembrokeshire and Ceredigion that are affecting service provision throughout the 7 day operating period. Long term sickness has improved for one clinician but offset by medical retirement of another. The Clinical Lead has 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. Need for formalised workforce plan and redesign is still required - reflected in	Review the rationalisation of overnight temporary service change.	Richards, David	~~31/05/2021~~ ~~30/09/2021~~ 31/12/2021	All operational staff are aware that this review is now underway as of Feb21. The review is being designed and will look at patient demand and experience, and service risks. As of May21 this is being actively reviewed with the Director of Operations. The consultations will now take place into Jun21 with outcomes to be reported to the relevant UHB Committees in Sep21. Jul21- A patient and staff survey to be released and SDM to write paper to Director of Operations on service change. Currently working with Workforce colleagues to develop a true multidisciplinary team.
		Implement 'RotaMaster' which will help with rostering going forward. Our issues with 'offer and accept', plus IR35, will be mitigated with the completion of this project.	Richards, David	~~31/08/2021~~ ~~30/09/2021~~ 31/12/2021	Admin team are currently building and inputting all services details. RotaMaster will then be tested before going live. As of Jul21 RotaMaster is still being built. Training sessions will become available once RotaMaster is in place and hopeful this will be completed by Dec21.

	IMTP submission. In relation to service demand, activity has increased a little over the summer 2021, but still have the same % of referrals to A&E and 999, with no increase in % of admissions. Covid continues to influence the risk-position, complicated by the inability to see red flow patients in an Out of Hours setting (option available for red flow patients is nearing completion). The focus on delivery of care via the telephone advice method is the significant factor in stabilising the risk at this time (70-80% of consultations is now dealt with on the phone)- but any reduction in capacity remains likely to require an increase in the risk level as the service delivery will be adversely affected.	Implement Locum Hub Wales.	Richards, David	Completed	Completed- Locum Hub Wales is live as of Jul21, however usage is currently limited due to geographical restrictions and other non Health Board issues, including issues with the system and small pool of Clinicians available who are already working in our Health Board. Remote working would be available but is of low utility when we need face to face cover.
		Recruit Health Board wide GP posts.	Richards, David	~~30/06/2021~~ 31/12/2021	Interviews taking place w/b 19/07/2021 for 5 GPs. Some of these GPs are finishing training, but will be recruited for referred enrolment. Further recruitment advert will be considered following these interviews.
		Short term (1-2 years), the aim is to recruit Advanced Practitioners of all grades, with the potential opportunity to provide applicants with appropriate training and career development eg prescribing training within the available budget.	Richards, David	31/12/2023	Future growth of the MDT mode will be on an incremental, opportunistic basis to prevent destabilising the wider system, as clinicians become available, or express an interest to join the service.
		In the long term (2-5 years), in cooperation with TCS, Workforce and national groups, to develop a programme to grow our clinical workforce, and to evolve and utilise a self-sufficient service which is fit for purpose, within available budget.	Richards, David	31/12/2026	Future growth of the MDT model will be on an incremental basis.
		Investigate the further use digital technology and platforms to deliver the OOH service alongside current practices	Richards, David	31/12/2022	Progress to be provided at next risk review

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
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			QSEAC OOH Update Sep19 & Feb20 QSEAC - Peer review - Feb20 QSEAC- Review of risk 129 - Oct20 QSEAC- Review of risk 129 Apr21 QSEAC- OOH paper Jun20 ET- Risk to OOH business continuity - Sep19 ET- OOH resilience - Nov19 & Jan20 BPPAC Quarterly monitoring	Lack of meaningful performance indicators.	Assess NHS 111 performance metrics to understand how they may influence Hywel Dda OOHs performance, and if a viable alternative - which may support improvement in shift fill.	Davies, Nick	Completed	New 111 Wales performance metrics are being prepared and will soon be circulated for review.
	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								
	QSEAC monitoring	2nd								
	Issues raised, and performance Matrix reviewed, at National OOH forum (bi-monthly, attended by WG)	3rd								
	WG Peer Review Oct 19	3rd								

Date Risk Identified:	Sep-21			**Executive Director Owner:**	Carruthers, Andrew	**Date of**	Oct-21
Strategic Objective:				**Lead Committee:**	Quality, Safety and Experience Committee	**Date of**	Dec-21

Risk ID:	**1218**	**Principal Risk Description:**	There is a risk inpatient paediatric services will become overwhelmed. This is caused by an increase in RSV (Respiratory syncytial Virus) and other serious respiratory virus presentations earlier in the year than anticipated lasting over the winter period, peaking in November 2021. This could lead to an impact/affect on the paediatric service provision and wider unscheduled care pathway (including WAST, primary care and emergency	**Risk Rating:(Likelihood x Impact)**	**No trend information available.**
				Domain:	Service/Business interruption/disruption
				Inherent Risk Score (L x I):	5×3=15
				Current Risk Score (L x I):	4×3=12
				Target Risk Score (L x I):	3×3=9
				Tolerable Risk:	6
Does this risk link to any Directorate (operational) risks?				**Trend:**	⟷

Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
Potential for severely compromised pathway due to environmental and workforce constraints. The RSV case-presentations to date have been sporadic in nature and some confidence is building that any further surge may present in this way, reducing the need for maximum surge capacity in a concentrated 24 hour period. This is caveated by patient behaviour, social mixing and communicable transmission.	The Cilgerran ward environment will be improved by remedial works and increased capacity will be gained to support patient flow - ahead of predicted 50% surge. However following review of availability of the required staff to manage a surge, the target risk score has increased to 9. This risk will then be tolerated as no further action can be taken to reduce this risk further.

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	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
New level 2 HDU (3 bed) unit developed for respiratory patients in support of wider critical care network. 3 consultant , 1 registrar, 1 SHO in place to support additional activity. WG support for cost pressures associated with RSV indicated. Escalation and surge plan associated mitigations. Gold/Tactical support for demountable unit and remedial estates work	30 wte nurses and 10.9 wte HCSW required to support maximum surge Significant restraints in Paediatric environment to support the increased bed capacity required.	Workforce RSV Focussed Group assessing potential for additional staffing.	Davies, Nick	Completed	Plan in place to systematically redeploy available staff during times of surge.

to support additional bed capacity within Cilgerran Ward. Significant training programme in place and rolled out to medical and nursing staff. Surge control group established to meet as and when required. Infection Control Policy in place and part of surge plan development. Purchase of additional respiratory equipment and consumables to a demand. Raising public awareness through use of PHW information. Daily Reviews of staffing Revised local choice framework (ring-fencing redeployment of paediatric staff)					Renting demountable unit for Paediatric services for 12 months for storage, staff room and office space allowing ward space to be maximised.	Davies, Nick	30/11/2021	Business Case completed and signed off and STA submitted.
					Ensure that all work to fully commission demountable is undertaken and there are no delays to it being fully operational, eg protocols in place, FRA undertaken, etc	Davies, Nick	30/11/2021	Work underway.

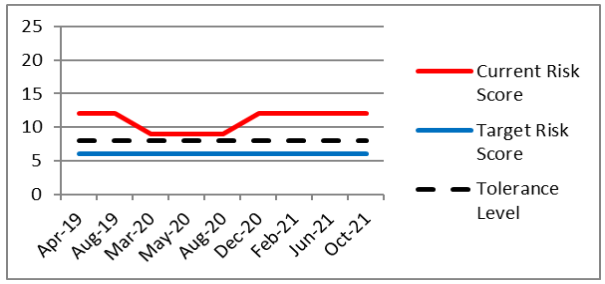
ASSURANCE MAP						Gaps in ASSURANCES				
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**	**Control RAG Rating (what the assurance is telling you about your controls**	**Latest Papers (Committee & date)**	**Identified Gaps in Assurance:**	**How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
	Operational RSV delivery group with multi service membership	1st				None				
	Daily sitreps scrutinised by service leads	1st								
	Surge control group to manage escalations	1st								
	Silver overseeing delivery of the RSV Plan	2nd								
	WG Deputy Medical Officer & Chief Nursing Officer assured by HB response	3rd								

	RSV National Group	3rd						

Date Risk Identified:	Sep-18	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Oct-21
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Dec-21

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

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



Does this risk link to any Directorate (operational) risks?

Rationale for CURRENT Risk Score:

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

Rationale for TARGET Risk Score:

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Working with all Wales Cancer Network to gain full understanding of implications of new pathway. Implementation Group established, reporting to Cancer Board with awareness / engagement sessions held on each hospital site. Shadow monitoring in place	Anticipated significant gaps within key diagnostic services to address required levels of activity to support SCP. Full engagement for all	Demand & capacity assessment work continuing. Solutions will necessitate regional cooperation to address anticipated capacity gaps.	Humphrey, Lisa	~~31/03/2020~~ ~~31/03/2021~~ 31/12/2021	Initial planned work with Delivery Unit suspended and will be under constant review in light of COVID and recovery planning phase. Work is ongoing .

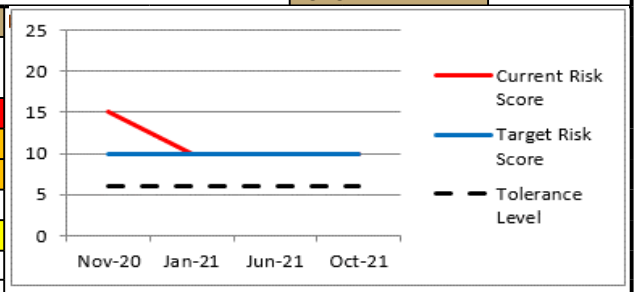
Shadow monitoring in place. Further Demand & Capacity exercise planned 2020/21 with support from Delivery Unit. New Cancer tracking module in W-PAS now fully operational as of Dec19 with tracking team in place from Dec19 to allow patients to proactively tracked through treatment pathways. Routine daily communication feed from ED to cancer information team which helps identify the point of suspicion. COVID-19 escalation plan in place. Monitoring data of patients whose treatments have changed or suspended (some through patient choice) as a result of COVID-19. A 4-week follow up process has been implemented for these. Utilisation the private sector for surgery during COVID-19. Joint working with regional colleagues to offer patients on a tertiary pathway surgery locally. Resumed aerosol generated diagnostics cross all 4 hospital sites.Due to the current COVID situation, these services are now being scaled back with Endoscopy services being mainly centralised in GGH. Reinstated high acuity elective Cancer surgery with green pathway and green ITU/HDU has commenced on PPH and BHG sites as of 06/07/2020, and WGH Intermediate surgery from 10/08/20. Due to the current COVID situation, only urgent cancer elective surgery will be carried out from the 21st December for a period of 4 -6 weeks due to staffing levels. All patient are being clinically prioritised to ensure no harm is caused by the delay. 7 Day Diagnostic Group and RDC. FIT and Digital Delivery of Care.	Full engagement for all supporting services. Performance is lower than USC/NUSC published performance. Key diagnostic information systems do not support effective demand / capacity planning. Need for new, streamlined optimal clinical pathways to reduce diagnostic demand and expedite assessment pathways.	See above re diagnostic services plus improved systems to support identification of 'date of suspicion'.	Humphrey, Lisa	~~31/03/2019~~ ~~31/08/2019~~ ~~31/07/2020~~ ~~31/10/2020~~ ~~31/03/2021~~ 31/08/2021	HB performance compares well with other HBs however below current SCP performance level. Ongoing work in progress with OPD, Diagnostic & ED teams along with the informatics department to improve real time identification of date of suspicion. Informatics are beginning to pick up routine reporting requests which were on hold due to COVID-19.
		Each MDT to review and adopt recommended optimal tumour site specific pathways	Humphrey, Lisa	~~31/08/2020~~ ~~30/09/2020~~ ~~31/03/2021~~ 31/12/2021	Each MDT is currently assessing implications of published proposed pathways. A Macmillan Cancer Quality Improvement Manager post which was developed to work with the teams with regards to implementing the new pathways has been appointed to and the new appointee took up post on 1st November 2020. Agreement over funding was delayed as a result of COVID-19.
		Explore opportunities for alternative providers to address tertiary centre delays for cancer treatment.	Humphrey, Lisa	Completed	Some arrangements were agreed however these have been suspended due to COVID-19, however COVID has provided opportunities to enable new arrangements to be put in place with regional centres.

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

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Rayani, Mandy	**Date of Review:**	Oct-21
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Health and Safety Committee	**Date of Next Review:**	Dec-21

Risk ID:	**1016**	**Principal Risk Description:**	There is a risk of increasing COVID infections across the Health Board. This is caused by staff and others not adhering to the Health Board guidance and National Social Distance legislation. This could lead to an impact/affect on increased levels of staff absence due COVID infection and self isolation, some essential services being closed leading to longer waiting times and delays for treatment for patients, enforcement action/fines from HSE for non-compliance with Social Distancing legislation.

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):	2×5=10
Tolerable Risk:	6
Trend:	⟷



Does this risk link to any Directorate (operational) risks?

Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
Social Distance risk assessments have been undertaken that highlight ways to allow services to be re-introduced while maintaining the social distance measures, however successful management of the risk depends on staff, visitors or patients adhering to the social distance guidance or using the 'Key Controls' measures in place. The current risk remains at 10 as whilst the social distance measures/legislation remains there does appear to be an increase in the numbers of staff absent either because of close contact family members being off or contracting covid-19 themselves.	The TARGET score focuses on reducing the likelihood of an incident as the impact score would remain at 5 (as outlined under CURRENT score). By introducing effective social distancing measures such as screening in high priority areas and alternative solutions in other areas, such as PPE, staff would be able to man more areas thus allowing services to resume as far as reasonably practicable. In terms of inpatient bed space, by reviewing all ward spaces and field hospitals against current guidelines and introducing either physical barriers or increasing spaces, as many services as possible will be able to return, however, strict adherence to the controls in place will be required to meet the target score.

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	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Social distancing guidance in place for staff and is available on the intranet # Safety screen installations in hospital and ward/clinic reception areas # Instructional social distance posters, phones messages and floor signs # Hand sanitisers stations	Due to the relaxation of COVID-19 rules outside of health settings, staff, visitors or patients are less likely to adhere to	Review current home working guidance for agile/homeworkers	Harrison, Tim	~~30/09/2021~~ 31/12/2021	Working from home assessment in development.

# Personal protective equipment (PPE) # Reducing room capacities to allow for social distancing # Use of IT systems e.g. Microsoft Teams to reduce the need for face to face meetings # Reduction in travelling between sites # Home working being encouraged where possible # Accommodation facilities for medical staff have been risk assessed and alterations made in line with social distance measures. # SD information on patient appointment letters, leaflets # One way pedestrian walkways # Controlled access into surgical wards and theatres # Hospital bed screens installed in identified wards in order to maximise inpatient capacity and minimise bed losses # Additional accommodation in Trinity St David's Campus to improve social distancing # Patient visiting arrangements recently updated including agreed timeslots and management arrangements	the social distance measures in healthcare Staff returning to work on sites may lead to a reduction to the availability of staff room and changing facilities as these spaces return to their original use. Longer term working from home/agile working will need further consideration for ensuring compliance with DSE Regulations. Compliance with new WG government	Increase screens in patient waiting areas to support compliance with new WG SD guidance to provide additional protection for patients whilst maintaining capacity	Chiffi, Simon	31/12/2021	Work is underway.
		Issue new guidance to operational & corporate management and request them to review social distancing arrangements and risk assessments in their areas in line with latest WG guidance, eg, non-clinical areas can reduce SD to 1m	Harrison, Tim	30/11/2021	SBAR containing latest WG guidance to be considered by Executive Team, prior to communicating across HB.

ASSURANCE MAP						Gaps in ASSURANCES				
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**	**Control RAG Rating (what the assurance is telling you about your controls**	**Latest Papers (Committee & date)**	**Identified Gaps in Assurance:**	**How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
	Oversight is provided by the Social Distancing Cell, Chaired by Director of NQPE	1st				None identified.				
	Reviewing grade 4&5 incidents (RIDDOR reportable) involving staff contracting hospital acquired COVID	1st								
	Social Distancing Cell reports into Silver and Gold Groups	2nd								
	HSE visit Oct21 with no issues identified across the 2 acute and 2 community sites	3rd								